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MEDICAID

The Trade-off between Cost Containment and Access to Care

John F. Holahan
Joel W. Cohen

The Changing Domestic Priorities Series
John L. Palmer and Isabel V. Sawhill, Editors

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FOREWORD

This book is part of The Urban Institute's Changing Domestic Priorities project. The project is examining changes that are occurring in the nation's domestic policies under the Reagan Administration and is analyzing the effects of those changes on people, places, and institutions.

One of the major programs in the nation's "social safety net" that has undergone considerable evolution in the 1980s is Medicaid, the basic source of health care financing for the low-income population. Before 1982, Medicaid spending had been growing at real (inflation-adjusted) rates in excess of 5 percent a year. The Omnibus Budget Reconciliation Act (OBRA) of 1981 gave states new means of gaining control over Medicaid costs. The legislation mandated eligibility reductions, decreased federal matching contributions, and increased state flexibility in designing cost-control programs. The result has been an abrupt halt in real growth rates of Medicaid expenditures.

In this book John F. Holahan and Joel W. Cohen provide a detailed analysis of how and why Medicaid expenditures were brought under control by the states by disentangling the respective roles of the economic recession in 1981-82 and the OBRA legislation. The authors provide detailed descriptions of changes in eligibility policy and analysis of their impacts on program enrollment. Important evidence on the changes in enrollment for different age groups is presented and compared with changes in the underlying poverty population. And the cost-containment policies adopted for each Medicaid-covered service are discussed, along with new data that show the outcomes of these policies. The result is a clear empirical picture of which population groups and what Medicaid services have been most affected.

The book's central conclusion is that Medicaid cost-containment policies have been extremely successful. However, the authors believe that a number of problems remain. They argue that although some cost-containment policies

have been well designed and innovative and have resulted in increased efficiencies, others simply resulted in cutbacks with potentially undesirable consequences. The reductions in enrollment raise questions about the adequacy of the safety net covering America's poverty population because large numbers of children and elderly poor do not receive Medicaid assistance. For many others who are eligible, low levels of provider participation resulting in large part from cost-containment efforts raise questions about the true health insurance value of the program.

Finally, the authors examine the federal-state cost sharing formula and argue that it contains insufficient incentives for some states to provide adequate access for many of their poor, while at the same time it has encouraged other states to develop generous and expensive programs. They conclude with recommendations for a change in the way the Medicaid program is financed; the proposed change would require more heavily subsidized increased coverage for the poor in states with less generous programs and would strengthen incentives to contain costs in states where spending is currently at high levels.

Since passage of the OBRA legislation, there have been many attempts to describe state Medicaid activities, and abundant anecdotal evidence has accumulated on how the program has been changing. This book goes beyond these efforts and provides a rich source of empirical evidence on the fundamental changes taking place in the financing of health care for the nation's poor. Thus, it fills an important gap in public knowledge on these issues and makes clear that there is continued need to debate Medicaid reform.

John L. Palmer
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Joel W. Cohen is a research associate with the Health Policy Research Center at The Urban Institute. He has conducted research on a variety of health care issues, focusing on analyses of financing and reimbursement methods. His publications include an examination of how public programs are used to finance long-term care nationwide and a comparative evaluation of alternative nursing home capital reimbursement methodologies. He has also conducted studies and written papers analyzing alternative hospital reimbusement systems, the impact of legislative changes on spending under federal health care programs, and options for increasing access to care for the chronically mentally ill.

CHAPTER 1

INTRODUCTION

In the 1981 Omnibus Budget Reconciliation Act (OBRA), Congress mandated what are perhaps the most substantial changes in the Medicaid program since its inception in 1965. Aimed at curbing what had previously been uninterrupted and rapid growth in Medicaid costs, the Medicaid provisions of OBRA set new limits on eligibility for the program, reduced the federal share of program costs, and increased the flexibility of the states for managing the program. At the same time, the ability of the states to finance their share of Medicaid costs was constrained by a severe recession and continuing high inflation rates. The outcome of all these phenomena was the first reduction in real spending for Medicaid in the history of the program.

Less dramatic but equally noteworthy was the contribution of federal and state cost control efforts to some fundamental changes in the nature of the Medicaid program. Medicaid was originally conceived as a way of broadening the public provision of medical services to the poor and of ensuring more uniformity in service provision among the states than had prevailed under the Kerr-Mills program, Medicaid's predecessor. But over the years Medicaid has increasingly concentrated on providing long-term institutional care to the elderly and the disabled, many of whom are not officially poor. The share of resources allocated to acute care services for adults and children has correspondingly declined. This shift in spending priority accelerated after 1981. In addition, vast differences in eligibility, coverage, and benefits have persisted among the states. Because OBRA expanded the range of choice open to the states, we might expect more divergence in the future.

The potential inequity in coverage and benefits among states and population groups has long been a subject of concern to health care finance administrators but in recent years this concern has been overshadowed by Medicaid cost problems. Expenditures under the program constituted a large

and ever-growing share of the budget for many states and an open-ended liability for the federal government. In the ten years preceding the implementation of OBRA, Medicaid spending for the federal and state governments grew 40 percent faster than federal and state revenues (HCFA 1984a). The question now is, has the uncontrolled growth of the Medicaid program been permanently arrested? And, as a corollary, should health care finance administrators and policymakers now focus more of their attention on problems of equity?

We do not have definitive answers to these questions, but interest in the answers motivates our analyses. In this book we examine a number of specific questions, the answers to which shed some light on the larger policy issues. On balance, the data presented here suggest that the major sources of Medicaid cost growth in the past will prove less problematic in the future. That is, despite the economic recovery and the watering down of some of the OBRA provisions in subsequent legislation, we probably will not see a return to "business as usual" (although the growth potential of several components of the program remains of concern). Also, our analysis indicates that problems of access to service, quality of service, distribution of tax burden—equity, in general—have certainly not been ameliorated by recent program changes and may have been exacerbated. Overall, however, the aim of this volume is not to come up with detailed forecasts or policy prescriptions, but simply to document and call attention to the real changes that have taken place in the Medicaid program over the past several years.

In chapter 2 we examine the broad patterns of Medicaid spending over the three years preceding (1978–81) and three years following (1981–84) the passage of OBRA. Specifically, the chapter addresses the following questions:

- Why has Medicaid spending historically proved so hard to contain?
- How do the effects of the various OBRA provisions compare with the effects of the recession on the post-1981 slowdown in spending?
- Are lower nominal growth rates in spending due to smaller increases in the number of recipients, lower underlying inflation rates, or declines in real growth rates?
- Are lower growth rates likely to prove temporary or permanent?

Also, the chapter uses the most recent available data on Medicaid spending by state to explore the magnitude, nature, and origins of interstate variations in spending. In particular, the chapter addresses the following questions:

- Do interstate variations arise from differences in number of recipients per capita, expenditures per recipient, differences in the mix of services (for example, long-term care versus acute care), or broader coverage

of people in the more costly categories of eligibility (such as the aged or disabled, as opposed to adults or children)?
- What are the relative contributions of demographic characteristics, per capita income, federal matching rates, and the availability of health care resources?

In chapter 3 we take up the controversial issue of changes in program eligibility, addressing the following questions:

- Were some eligibility groups hit harder than others by OBRA?
- Are changes in the generosity of the program among the different eligibility groups a consequence of deliberate targeting through eligibility policy or an indirect consequence of the fact that some groups tend to be disproportionate users of services that have been more tightly constrained?
- How do the changes in eligibility compare with the changes in poverty?
- How much does eligibility vary among states?
- Have states responded to federal cutbacks by changing eligibility policies that remain within their control?

The way in which expenditure changes are distributed among services raises several other questions that have long-term implications for the evolution of the Medicaid program. In chapters 4 and 5, we examine the changes in expenditures for the two basic categories of Medicaid services, acute care and long-term care. In particular, we consider these questions:

- Which services have been hardest hit?
- Are these the services that have been traditionally cut back in hard times or did the OBRA legislation permit restraints that could not previously have been applied?
- Do declines in growth rates reflect fewer recipients, lower underlying inflation rates, or lower real growth rates?
- What is the relation between policy changes and lower growth in expenditures?
- How have acute care services fared versus long-term care, hospital inpatient versus ambulatory, institutional versus noninstitutional long-term care services, mandatory versus optional services?

Finally, in chapter 6, we review the evidence provided in the preceding chapters and discuss the principal findings of the study. We pose a number of questions that are essentially unanswered about the programmatic changes for different population groups, and we briefly survey various options for reforming the financial structure of the Medicaid program. We argue that, in

general, states have been very responsive to the financial incentives facing them and have contained costs quite successfully in recent years. The principal remaining problems are ones of access, particularly to acute care services and perhaps to long-term care services as well. The considerable discrepancies in benefits among the states also remain problematic. We conclude by outlining a proposal that would change federal arrangements for financial participation to deal with these problems while retaining strong cost-containment incentives.

CHAPTER 2

HOW MUCH IS SPENT ON MEDICAID AND WHY?

The question of who should pay for what services for whom under the Medicaid program has never been systematically addressed by policymakers. By almost everyone's account, Medicaid was enacted as a sort of afterthought to Medicare; beyond the broad aim of expanding health care services for the poor, particular program goals were never clearly articulated, and program costs were not clearly anticipated. The federal statute establishing the program, Title XIX of the Social Security Act, makes available federal matching grants to states that choose to provide certain medical services to certain populations—basically, low-income populations meeting the eligibility requirements of the Aid to Families with Dependent Children (AFDC) program or the Supplementary Security Income (SSI) program. But within the federally prescribed limits, states have always had wide latitude in defining the populations eligible for benefits and the benefits for which they are eligible. Consequently, as noted in chapter 1, the nature of the Medicaid program—and program expenditures—have varied enormously across the states.

In part because of the wide latitude of state choice, Medicaid expenditures have also proved particularly resistant to control. Although expenditures rose rapidly throughout the 1970s (at a rate of 15.6 percent a year between 1973 and 1979), severely squeezing many states' budgets, few states consistently made cost control a high priority. Their failure to do so may be partially explained by the political climate at the time: from the mid-1960s to the mid-1970s, poverty program administrators in general were preoccupied with accommodating public pressure for expanded access to program benefits. Also, the simplest method of controlling costs—cutting eligibility for the program—could actually end up increasing the overall cost to the state and its taxpayers of providing medical care to the poor. States, counties, and cities have always borne a large share of the responsibility for providing care

to indigent populations. Because some level of government has to serve as provider or payer of last resort for these populations, changing the Medicaid eligibility rules was perceived as unlikely to reduce costs and quite likely simply to shift fiscal burdens from a higher level to a lower one.

State incentives for cost control were further limited by federal rules regarding the reimbursement of services from providers—physicians, hospitals, nursing homes, pharmacies, and the like. Until the 1981 Omnibus Budget Reconciliation Act (OBRA), Medicaid programs were basically required to pay hospitals on a reasonable-cost basis (or to design an alternative arrangement meeting other federal requirements). For other services, rates of payment had to be sufficient to maintain patient access. Although "maintaining access" is a difficult concept to define, the requirement imposed a practical though vague limit on how low Medicaid rates of payment could go. States could and did pay below-market levels for many services, but not so far below as to disregard completely the underlying rate of inflation. Thus, a major cause of Medicaid cost growth has been, and will continue to be, the inflation in costs of medical services.

An additional disincentive for cost control arises from the open-ended nature of the federal match, which often encourages the substitution of Medicaid spending for other state (or local) spending for which the federal match, if any, is less than Medicaid's. The federal government matches state expenditures for care on a percentage-of-payment basis, with the percentage inversely related to a state's per capita income relative to the national average. (The maximum federal share in 1980 was 77.55 percent, and the minimum, 50 percent.) Thus, incentives for substitution appear to be stronger for poorer states and for states that have undertaken significant health care responsibilities with their own funding. Regardless of the relative power of the incentive, virtually all states have felt the lure of substitution to some extent. Forty-seven states, for example, have taken advantage of the Medicaid option of care for the mentally retarded in intermediate care facilities (ICF/MRs) to help pay for state institutional care for the mentally retarded. Similarly, many states use Medicaid to provide services that would otherwise be provided under Title XX (social services) and Title V (maternal and child health) of the Social Security Act, because federal dollars for these programs are limited and marginal spending must be funded entirely with state dollars.

Furthermore, state efforts to contain costs have been inhibited by the large number of federal regulations governing Medicaid programs, which makes program spending hard to predict and to control. Federal law dictates the basic design of the program—eligibility through entitlement, certain mandatory benefits, free choice of provider, cost-based reimbursement, and so

on—and although the 1981 legislation significantly increased state flexibility in these areas, the federal constraint is still considerable.

Finally, beneficiary and provider interest groups have substantial political influence, which is often aligned against cutbacks. Not all beneficiary or provider groups are equally potent; the aged, for example, seem more influential than other groups, and nursing homes stronger than physicians or pharmacists. Also, influence varies from state to state. But all states face some form of political constraint that limits the potential for program shrinkage.

The passage of OBRA in 1981 did much to change both the political climate and the incentives and regulations facing the states. First, and perhaps most controversially, the legislation forced eligibility cutbacks on the states. Although these changes were principally a method of reducing welfare eligibility and not a Medicaid cutback per se, the changes had important implications for Medicaid. (The particular cutbacks and their consequences are examined in the next chapter.) Second, and perhaps most important in terms of overall cost control, the legislation eliminated the federal requirement for reimbursement of all "reasonable" (actual) hospital costs, thus encouraging states to adopt "prospective" payment systems. The reimbursement rates established by the states are now required only to be "reasonable and adequate" in terms of meeting the costs of "efficiently and economically operated facilities" and of assuring "reasonable access" to services of "adequate quality." As interpreted by federal administrators, the change in the legislative language allows states to set caps on the following year's payments that are independent of actual hospital spending or increases in the costs of goods and services used by hospitals.

Third, the legislation made Medicaid spending relatively less "attractive" versus spending from other sources by lowering the federal matching rate formula by 3 percent in fiscal 1982, 4 percent in fiscal 1983, and 4.5 percent in fiscal 1984. The reductions were softened by various provisions rewarding states for cost control efforts and reducing the impact in states with high unemployment rates. The Reagan administration had originally proposed a cap of 5 percent on the growth of the federal Medicaid share for 1982. A fixed federal contribution would have greatly increased the pressure on states to control expenditures, because each marginal dollar would have had to come from state revenues. In response to state opposition, the matching rate reductions were legislated in lieu of the cap. Nonetheless, Congress sent a clear signal that the era of expansion was over.

Fourth, the legislation substantially increased state flexibility for administering the Medicaid program by eliminating various federal restrictions and instituting waivers for others. States were, for example, given greater freedom

to experiment with health maintenance organizations (HMOs) and other prepayment and alternative delivery systems. States were also allowed to apply for waivers of the numerous restrictions governing home and community-based care, thus enabling them to explore potentially less expensive alternatives to institutional care for particular cases. The full fiscal impact of these and other such provisions for more flexible administration, however, will not be known for several years, after the states have had time to experiment and adapt.

Finally, and least tangibly, the era of austerity in social program spending inaugurated by OBRA may serve to strengthen the resolve of state policymakers with regard to future spending on Medicaid. Faced with increased demand for social services of all sorts to compensate for federal cutbacks, the states may find that their Medicaid lobbies look much less formidable than previously.

Whatever the future holds, in the immediate aftermath of OBRA, real Medicaid expenditures declined for the first time in the history of the program. But since the implementation of OBRA coincided with a severe recession, it is difficult to isolate the influence of federal policy changes from that of the economy in general. Recessions affect state Medicaid spending in two main ways: first, by increasing the pool of people eligible for welfare, and thus for Medicaid; and second, by reducing real per capita income, and thus also tax revenues available for public programs in general. Because most states face some balanced-budget requirement, a recession compels them to cut spending or raise taxes, or both. The fact that Medicaid expenditures rose again with economic recovery (although by no means as rapidly as in the pre-OBRA years) attests to the influence of the recession on state spending decisions.

In the remainder of this chapter, we examine the changing patterns of Medicaid expenditures in more detail, with the aim of assessing the impact that the various phenomena already discussed have on program growth. We look first at aggregate program spending, both by type of service (acute or long-term care) and by category of recipient. We then examine interstate variations in spending from several perspectives, and we conclude with an examination of the redistribution of funds across states resulting from state spending decisions.

What this examination shows is that although Medicaid is an integral part of what was termed the "social safety net" in the early 1980s, the Medicaid section of that net is spread very unevenly across the country for reasons that have little to do with the number of poor people and their need for medical care. In addition, over the past few years as potential indicators of need for Medicaid services—such as expanding poverty among adults and

children and increases in the proportion of the population over age sixty-five—have become more evident, the growth in Medicaid spending has slowed. In sum, a careful analysis of Medicaid suggests that although the program does function in a manner basically consistent with its federally legislated goals, inequity has become a problem. What is more, analysis suggests that the program could be improved, from a national perspective, without necessarily sacrificing any gains in efficency that have occurred over the past few years. First, however, we turn our attention to describing where the program stands now and how it has changed since the late 1970s. This discussion provides a framework for understanding thin spots in the Medicaid safety net and the effects of federal policy on Medicaid spending within the states.

Medicaid Spending, 1978–84

As is indicated by table 1, the pattern of Medicaid spending changed to such an extent after 1981 that we may justifiably speak of pre- and post-OBRA eras of the program. Between 1981 and 1984, Medicaid spending increased at a much slower rate than it had between 1978 and 1981, averaging

TABLE 1

TOTAL U.S. MEDICAID EXPENDITURES BY BROAD SERVICE CATEGORY, 1978–84
(Billions of Dollars)

Year or Period	*All Services*		*Acute Care*		*Long-term Care*	
	Nominal	*Constant*	*Nominal*	*Constant*	*Nominal*	*Constant*
1978	17.7	17.7	9.5	9.5	8.2	8.2
1979	20.2	18.5	10.6	9.7	9.6	8.8
1980	23.4	19.4	12.3	10.1	11.1	9.3
1981	27.7	20.7	14.6	10.8	13.1	9.9
1982	29.6	20.2	15.1	10.1	14.5	10.1
1983	32.4	20.5	16.6	10.3	15.7	10.3
1984	34.5	20.7	17.4	10.1	17.0	10.6
Average annual percentage change						
1978–81	16.1	5.3	15.3	4.2	17.0	6.6
1981–84	7.5	a	6.1	−2.1	9.0	2.2
1978–84	11.7	2.6	10.6	1.0	12.9	4.4

SOURCE: Health Care Financing Administration, Medicaid Expenditure Report 2082 (Baltimore, Maryland: HCFA, 1978 through 1984). Unless otherwise stated, all tables in this book are based on this source.

a. The rate of decline is less than 0.1 percent.

7.5 percent annually between 1981 and 1984, compared with 16.1 percent between 1978 and 1981, in nominal dollars. In constant dollars, spending was virtually unchanged between 1981 and 1984, whereas in the previous three years it had increased at an average annual rate of more than 5 percent. Thus, real spending growth essentially halted after 1981; a number of factors contributed, including the recession, the reduction in federal matching rates and other provisions of OBRA. (In this book, real expenditures refers to Medicaid expenditures deflated to 1978 dollars by a series of indices specific to Medicaid services. An explanation of the derivation of the Medicaid price index is provided in appendix A to this book.)

This slowdown was accompanied by a shift in the nature of the program, away from an acute care program for the disabled, poor adults (principally young mothers) and children and toward a long-term care program for the elderly and chronically ill.[1] Table 1, which divides total expenditures into spending for acute and long-term care, illustrates the increasing importance of the latter in overall expenditures. Because spending for long-term care increased faster in constant dollars than spending for acute care (29.4 percent versus 6.1 percent between 1978 and 1984), long-term care had become almost as important (in terms of spending) as acute care by 1984. In 1978 acute care accounted for 54 percent of total spending and long-term care 46 percent, but by 1984 acute care had dropped to 51 percent and long-term care increased to 49 percent. Although this shift in spending emphasis was under way before the passage of OBRA, it rose after 1981, as the table indicates.

In view of the increasing emphasis on long-term care, it is not surprising to find that aged, blind, and disabled people are consuming a mounting share of Medicaid resources. Although table 2 documents that real spending on each of these population groups grew more slowly after 1981, spending for other eligibility groups actually declined over the same period. Even before OBRA, spending for the aged and the blind and disabled was growing at faster rates than spending for adults ages twenty-one to sixty-five and children—and from a much higher base. In fact, spending for children under the AFDC program was growing so slowly that in real terms it was actually declining. Between 1981 and 1984, real spending on the elderly and the blind

1. Acute care services consist of hospital inpatient care; outpatient emergency room and clinic services; physician, laboratory, and X-ray services; prescription drugs, dental care, and "other" services, including podiatrists, chiropractors, and various therapists.

Long-term care services include nursing home care (both skilled nursing facilities, SNFs, and intermediate care facilities, ICFs), intermediate care facilities for the mentally retarded, inpatient psychiatric care, and home health care (including personal care in all years and home and community-based waiver services in 1984).

TABLE 2

TOTAL U.S. MEDICAID EXPENDITURES BY ELIGIBILITY CATEGORY, 1978–84
(*Billions of Dollars*)

	Elderly		*Blind and Disabled*		*AFDC Adults*		*AFDC Children*	
Year or Period	*Nominal*	*Constant*	*Nominal*	*Constant*	*Nominal*	*Constant*	*Nominal*	*Constant*
1978	6.3	6.3	5.6	5.6	2.6	2.6	3.2	3.2
1979	7.2	6.6	6.7	6.2	2.9	2.7	3.4	3.1
1980	8.8	7.3	7.7	6.3	3.3	2.7	3.8	3.1
1981	10.1	7.6	9.6	7.2	3.8	2.8	4.1	3.1
1982	10.8	7.5	10.5	7.2	4.1	2.8	4.1	2.8
1983	12.1	7.8	11.4	7.3	4.4	2.7	4.4	2.7
1984	12.8	7.9	12.4	7.4	4.5	2.6	4.8	2.8
Average annual percentage change								
1978–81	17.0	6.6	20.0	8.9	13.8	2.8	8.6	−1.9
1981–84	8.2	0.9	8.8	1.2	5.2	−2.8	5.0	−2.8
1978–84	12.5	3.7	14.3	5.0	9.4	−0.1	6.8	−2.4

and disabled grew by about 1 percent per year while real spending for AFDC adults and children declined about 3 percent annually.

If we disaggregate these changes in Medicaid spending into changes attributable to the number of recipients and changes attributable to expenditures per recipient, it becomes evident that most of the spending slowdown between 1981 and 1984 derived from slower growth in expenditures per recipient (table 3). At the same time that the number of recipients declined slightly, annual growth in spending per recipient dropped 4.5 percentage points, from 5.2 to 0.7 percent. The combination of 0.7 percent annual decline in number of recipients and 0.7 percent annual increase in expenditures per recipient left total spending virtually unchanged between 1981 and 1984.

Further disaggregation (table 4) reveals that the slowdown in growth of expenditures per recipient was greater for acute care services than for long-term care services, although it was evident for both. Growth in spending per recipient for acute care fell from 15.2 percent (1978–81) to 6.9 percent (1981–84) a year, whereas for long-term care it fell from 15.6 percent (1978–81) to 8.3 percent (1981–84) a year. These 1981–84 real rates of change translate into an average annual decline of 1.4 percent for acute care, compared with an average annual increase of 1.5 percent for long-term care. Moreover, at the same time that the number of acute care recipients was declining slightly, the number of long-term care recipients showed a small amount of growth.

TABLE 3

CHANGE IN TOTAL U.S. MEDICAID EXPENDITURES DUE TO CHANGE IN NUMBER OF RECIPIENTS AND CHANGE IN EXPENDITURES PER RECIPIENT, 1978–84

Year or Period	*Number of Recipients (Thousands)*	*Expenditures per Recipient (Dollars)*	
		Nominal	*Constant*
1978	20,455	866	866
1979	20,072	1,007	923
1980	20,205	1,160	961
1981	20,520	1,350	1,009
1982	20,150	1,467	1,000
1983	19,936	1,623	1,030
1984	20,068	1,717	1,031
Average annual percentage change			
1978–81	0.1	16.0	5.2
1981–84	−0.7	8.3	0.7
1978–84	−0.3	12.1	2.9

Finally, disaggregating the change in spending by eligibility category (not shown) shows that the slowdown in spending per recipient affected all four eligibility categories: for the aged and the blind and disabled the effect was to curb what had been rapid growth in expenditures per recipient, whereas for AFDC adults and children, the effect was to accelerate an already existing trend of declining spending. (Because of a reporting change in 1981, the double-counting of recipients in the latter time period increased. Thus, some portion of the declines is probably due to this double-counting.) Before 1981 real expenditures per recipient on the aged and the blind and disabled had increased annually by an average of 6.5 and 5.9 percent, respectively; after 1981 the average increase declined to 3.1 percent and 1.9 percent. Real spending on AFDC adults and children, in contrast, had been dropping annually by an average of 1.0 percent and 1.7 percent, respectively, before 1981 and dropped even faster thereafter (by 4.6 and 3.1 percent). Because spending per recipient was much lower for people in the AFDC categories to begin with, by 1984 the contrast was stark: expenditures per recipient for the aged and the blind and disabled were approximately five times greater than they were for AFDC adults and ten times greater than they were for AFDC children.

In summary, in the post-OBRA era overall growth in Medicaid expenditures has been arrested, and the shift in spending priority away from acute and toward long-term care has accelerated. This shift has been accompanied by an increased concentration of resources on the aged and the blind and

TABLE 4

CHANGE IN TOTAL U.S. MEDICAID EXPENDITURES DUE TO CHANGE IN NUMBER OF RECIPIENTS AND EXPENDITURES PER RECIPIENT, BY ELIGIBILITY CATEGORY, 1978–84

	Acute Care Services			*Long-term Care Services*		
Year or Period	*Number of Recipients (Thousands)*[a]	*Expenditures per Recipient (Dollars)*		*Number of Recipients (Thousands)*	*Expenditures per Recipient (Dollars)*	
		Nominal	*Constant*		*Nominal*	*Constant*
1978	20,455	465	465	1,912	4,285	4,285
1979	20,072	528	484	1,897	5,062	4,642
1980	20,205	608	501	1,962	5,681	4,741
1981	20,520	711	525	1,984	6,613	5,007
1982	20,150	750	500	1,938	7,455	5,195
1983	19,936	835	514	2,003	7,849	5,136
1984	20,068	869	503	2,024	8,406	5,237
Average annual percentage change						
1978–81	0.1	15.2	4.1	1.2	15.6	5.3
1981–84	−0.7	6.9	−1.4	0.7	8.3	1.5
1978–84	−0.3	11.0	1.3	1.0	11.9	3.4

a. Equal to total recipients under the assumption that all recipients receive at least one acute care service.

disabled; although the number of recipients in both the aged and the blind/disabled categories declined between 1981 and 1984, the expenditures per recipient continued to grow (albeit at slower rates than before OBRA). For AFDC recipients, the post-OBRA era has been one of greater austerity: the number of adults and children receiving Medicaid continued to rise, while the expenditures per recipient continued—at an accelerated rate—to fall. To the extent that this shift in resources has not been an explicit policy goal of the states, it raises a question about whether federal incentives for financing acute care and long-term care should be the same under the Medicaid program.

Why Has the Growth in Medicaid Spending Declined?

An analysis of the relation between specific policies and expenditures for particular services is presented in chapters 4 and 5. But behind decisions to adopt specific policies with the intent of effecting certain expenditure outcomes are factors reflecting the ability of states to spend and the incentives they face through the federal matching formula. To the extent that states respond to changes in matching rates with changes in their levels of spending,

the matching rates provide a method by which the federal government can differentially affect states' spending. We analyzed Medicaid expenditure trends during the 1979–84 period to determine the relative short-term impacts of the recession and OBRA's reductions in federal subsidies on state spending (Cohen 1986). The assumption behind his analysis was that states are likely to respond to transitory changes in spending determinants—for example, a temporary reduction in state revenue resulting from a recession—in ways that are different from the ways in which they respond to more permanent changes—for example, a fixed reduction in the size of a federal subsidy.

In analyzing the changes in state Medicaid spending patterns over the pre- and post-OBRA periods (1979–81 and 1981–84), we examined the role of three major factors: reductions in real state income, caused by the recession; increases in the pool of potential recipients (represented by the unemployment rate), also caused by the recession; and the reductions in matching rates mandated by OBRA. To control for cross-sectional variation, we used a set of dummy variables to represent factors affecting the level of spending in any individual state.[2]

The effects of the recession are represented by the per capita income and the unemployment rate variables, which should be positively related to state Medicaid spending, because higher income reflects greater ability to finance the program and higher unemployment reflects a larger potential pool of eligibles. The federal match also should be positively related to spending because it is inversely related to the cost to the state of providing services under Medicaid. Time variables representing each year were included to capture any trends in spending that were not accounted for by the other variables.

The results of the regression analysis are presented in table 5. Both income and the matching rate were in fact associated with variation in states' Medicaid spending; the federal match had a slightly greater impact than income did. The coefficients of 0.44 and 0.29, respectively, indicate that each 1 percent reduction in the federal match was associated with a 0.44 percent reduction in real Medicaid spending, whereas a 1 percent reduction in real income was associated with a 0.29 percent reduction in real spending. The unemployment rate was not associated with Medicaid spending over this

2. Cohen's model is known as a fixed-effects or covariance model. This technique controls for state-specific time-invariant factors that affect the level of each state's spending and thus allows the estimation of a time-series model with data covering only a few years. The coefficients derived using this technique represent the impact on Medicaid spending, aggregated over all the states, of the independent variables that vary over time within each state. See Judge (1985) or Kmenta (1971) for a thorough explanation of the various pooled time-series cross-sectional econometric models.

TABLE 5

REGRESSION RESULTS: THE IMPACT OF THE RECESSION AND OBRA ON MEDICAID SPENDING, 1979–84

Dependent Variable = Real per Capita Medicaid Expenditures	
Explanatory Variable	*Parameter Estimate (Log-linear)*[a]
Intercept	3.27**
	(2.39)
Real per capita income	0.29*
	(1.73)
Federal matching rate	0.44**
	(2.23)
Unemployment rate	0.03
	(0.63)
1979	−0.08†
	(−4.53)
1980	−0.04†
	(−2.15)
1981	[b]
1982	−0.02
	(−1.43)
1983	0.01
	(0.48)
1984	0.01
	(0.46)
Summary statistic[c]	
$\bar{R}^2$	0.96
F	141.49

a. The t-ratios are in parentheses.

b. Reference year (omitted variable).

c. State dummy variable not shown.

* Significant at the 0.10 level.
** Significant at the 0.05 level.
† Significant at the 0.01 level.

period, however, which may reflect the impact of OBRA's eligibility changes on the program. As described in the next chapter, the number of recipients actually declined between 1981 and 1983 even though the incidence of poverty was increasing.

Finally, the time variables show that the trend in spending after 1981 was different from the trend before that year, even after accounting for the

effects of the other explanatory variables. The decreasingly negative coefficients for the years before 1981 indicate that spending was rising between 1979 and 1981 after controlling for economic factors and the federal match. The coefficients for the years after 1981, however, indicate that this unexplained (that is, unaccounted for by the other variables included in the model) rise in spending stopped after 1981.

Thus 1981 appears to have been a watershed year for the Medicaid program. Although the immediate and dramatic halt in real spending growth must be partly attributable to the temporary impact of the recession and the OBRA matching rate reductions, the long-term outlook appears to have changed substantially. The program seems to be set on a new and much more gradual path of growth than the one it had followed through its earlier history; growth in program spending not attributable to real income changes and matching rate reductions seems to have been halted. This does not imply that no real growth should be expected after 1984. Real per capita incomes have risen since 1984, and federal matching rates were increased across the board in 1985. Finally, the analysis does not account for longer-term trends that could cause spending to increase, perhaps the most prominent of which is the increased aging of the population.

Variations in Medicaid Spending by States

In 1984, the state and federal governments together spent more than $34 billion on the Medicaid program. As might be expected, the spending varied dramatically across states, ranging from $27 million in Wyoming to $6.8 billion in New York. In fact, the majority of Medicaid spending tends to be concentrated in a relatively small number of states. New York alone, for example, accounted for almost 20 percent of the 1984 total, and California accounted for another 10 percent. These two states plus five others (Pennsylvania, Illinois, Michigan, Ohio, and Texas) were responsible for more than one-half of total 1984 Medicaid spending, and one-half of the states accounted for almost 90 percent of the total.

State spending on Medicaid services varies a great deal along a number of different dimensions that, unlike total expenditures, have little to do with the sheer size of a state's population. For example, Massachusetts and Texas spent similar amounts on Medicaid in 1984, but by almost any other measure (expenditures per recipient, expenditures as a percentage of state income, and so on) their Medicaid programs were very different. As we explore in later chapters of this book, the large differences in Medicaid programs across states result from the wide latitude that federal regulations give states in their choice of eligibility criteria, service coverage, and payment methodologies.

The differences in states' willingness to spend are of concern for two reasons. First, low levels of spending may reflect limited access of the poor to medical care in some states. One of the objectives of the Medicaid program was to reallocate resources from wealthier to poorer states and thereby equalize this access. Although poor states now spend more than they otherwise would have, population coverage and program spending in most low-income states are below those of most wealthier states. This situation suggests that the redistributional objectives of the program have not been met. Second, high levels of program spending may reflect transfers of funds from poorer to richer states. High levels of expenditures are not a problem if they reflect a state's choices on how best to maximize the welfare of its citizens and if the state's spending at the margin comes from its own resources. But if high levels of spending in some states are financed by the contributions of other less wealthy states, the expenditures are a problem.

The extreme variation in levels of Medicaid spending across states suggests similar cross-state variation in the availability of medical care for the poor. To examine this issue more closely, table 6 shows the variation in Medicaid spending across states on a number of different dimensions. In 1984, per capita spending on Medicaid ranged from $382 in New York to $52 in Wyoming; the national average was $148. The number of people receiving Medicaid services varied from highs of more than 12 percent in California, Kentucky, Michigan, New York, and Rhode Island to lows of less than 4 percent in Idaho and Wyoming. There was also more than a threefold variation in spending per recipient, ranging from $738 in West Virginia to $3,070 in New York.

This extreme variation in per capita spending across states existed for both acute and long-term care. Variation in population coverage ratios across states was similar in magnitude for the two service types, with each showing approximately sixfold differences between the highest and lowest states. The variation in expenditures per recipient was also quite wide, ranging from $424 in West Virginia to $1,346 in Alaska for acute care, and from $5,624 in Kentucky to $13,010 in Alaska for long-term care.

Table 7 attempts to capture the relative generosity of states with respect to Medicaid by presenting data on Medicaid expenditures per poor person across states. Nationally, Medicaid expenditures per poor person averaged $747 in 1979 (the most recent year for which reliable poverty figures are available for all the states). The differences between the high- and low-spending states were substantial—more than $1,500 at the extreme—and generally reflected regional differences. Seven states, all in the Northeast and upper Midwest, plus the District of Columbia spent at a rate in excess of $1,000, whereas twenty states, almost all in the South and West, spent less

TABLE 6

MEDICAID EXPENDITURES PER CAPITA, RECIPIENTS PER THOUSAND POPULATION, AND EXPENDITURES PER RECIPIENT, 1984

State	*All Services*		
	Expenditures per Capita	*Recipients per 1,000 People*	*Expenditures per Recipient*
Total United States	147.81	86.09	1,716.99
New York	381.67	124.34	3,069.60
Rhode Island	246.12	120.07	2,049.74
Minnesota	229.47	81.75	2,807.11
Massachusetts	229.02	96.44	2,374.72
Wisconsin	191.16	103.09	1,854.31
Michigan	179.54	127.29	1,410.45
Maine	179.18	105.40	1,699.95
Connecticut	174.94	69.78	2,506.93
Vermont	159.04	100.42	1,583.71
Louisiana	154.08	85.69	1,798.01
Ohio	151.30	94.37	1,603.26
Pennsylvania	148.98	89.05	1,673.11
Illinois	146.53	90.88	1,612.26
Arkansas	145.28	82.10	1,769.50
North Dakota	145.21	49.13	2,955.45
New Jersey	139.47	79.43	1,755.84
Maryland	137.63	74.52	1,846.94
Kentucky	131.00	126.06	1,039.19
California	128.11	132.51	966.81
South Dakota	127.24	46.11	2,759.56
Hawaii	127.16	91.83	1,384.71
Oklahoma	120.39	76.55	1,572.78
Mississippi	120.27	116.41	1,033.12
Alaska	118.04	48.14	2,452.24
Montana	117.52	56.45	2,081.88
Indiana	117.34	49.46	2,372.20
Tennessee	112.88	73.20	1,541.95
New Hampshire	112.75	40.36	2,793.58
Iowa	111.80	68.92	1,622.09
Delaware	111.27	77.08	1,443.48
Washington	110.56	60.27	1,596.11
Georgia	104.57	75.21	1,390.39
North Carolina	99.09	55.23	1,794.13
Kansas	97.67	64.62	1,511.54
Missouri	96.30	71.24	1,351.85

TABLE 6 (*Continued*)

State	All Services		
	Expenditures per Capita	*Recipients per 1,000 People*	*Expenditures per Recipient*
Colorado	94.34	48.91	1,929.07
New Mexico	93.12	58.30	1,597.04
Nebraska	93.11	53.82	1,730.10
Texas	91.66	44.74	2,048.83
Virginia	91.35	53.49	1,707.91
Alabama	90.45	79.11	1,143.34
South Carolina	89.41	70.12	1,275.12
Oregon	87.18	52.14	1,672.23
Utah	74.30	41.98	1,769.79
Nevada	72.23	30.12	2,398.51
Florida	71.73	52.13	1,376.03
West Virginia	70.13	95.07	737.62
Idaho	65.89	36.51	1,804.62
Wyoming	52.05	28.75	1,810.88

than $500. As can be inferred from the table, the more generous states tended to be those with lower proportions of poor people in their population. There is, in fact, a negative correlation ($r = -0.43$) between percentage of the population in poverty and spending per poor person. Among the seventeen states that spent more per poor person on Medicaid than the national average, only two had greater-than-average (12.4 percent) percentages of poor people in their population, while among the thirty-two states with less than average spending, seventeen had a greater-than-average poverty population.

It would be tempting to account for the lower spending levels among the poorer states by hypothesizing that these states are trading off broader eligibility for lower spending per eligible person; but this hypothesis is refuted by a comparison of the data in table 7 with data in table 6. All but four of the states with an above-average proportion of their population in poverty were below average in Medicaid spending per capita as well as per person in poverty. Thus, these data suggest that variations in Medicaid spending are not accounted for by variations in need.

In an effort to determine the extent to which these cross-state variations reflect ability to pay for the program, rather than simply political preferences, we examined state Medicaid spending relative to state income (table 8). As

TABLE 7

MEDICAID EXPENDITURES PER PERSON IN POVERTY, 1979

State	*Expenditures per Person in Poverty*	*Percentage of Population in Poverty*
Total United States	747.35	12.4
Massachusetts	1,769.75	9.6
New York	1,568.92	13.4
Wisconsin	1,553.96	8.7
Rhode Island	1,424.49	10.3
Minnesota	1,298.48	9.5
District of Columbia	1,242.31	18.6
Connecticut	1,217.59	8.0
Michigan	1,084.78	10.4
New Jersey	982.55	9.5
California	943.43	11.4
Pennsylvania	935.91	10.5
Hawaii	900.34	9.9
Vermont	896.66	12.1
Maine	870.68	13.0
New Hampshire	812.38	8.5
Maryland	803.02	9.8
Illinois	760.18	11.0
Washington	759.26	9.8
Kansas	714.24	10.1
Iowa	696.68	10.1
Alaska	684.85	10.7
Oklahoma	653.86	13.4
Ohio	620.79	10.3
Indiana	613.69	9.7
Oregon	598.66	10.7
Montana	572.72	12.3
Delaware	565.09	11.9
Nebraska	561.41	10.7
Colorado	561.36	10.1
North Dakota	533.46	12.6
Virginia	489.39	11.8
Utah	488.75	10.3
Arkansas	473.38	19.0
Nevada	471.45	8.7
Texas	451.18	14.7

TABLE 7 (*Continued*)

State	*Expenditures per Person in Poverty*	*Percentage of Population in Poverty*
Louisiana	450.55	18.6
Georgia	440.23	16.6
South Dakota	438.16	16.9
Tennessee	426.88	16.5
North Carolina	407.47	14.8
Kentucky	403.85	17.6
Idaho	393.67	12.6
South Carolina	378.98	16.6
Missouri	368.19	12.2
Mississippi	334.37	23.9
West Virginia	320.19	15.0
Wyoming	311.57	7.9
Alabama	311.31	18.9
Florida	270.36	13.5
New Mexico	262.61	17.6

was true with each of the preceding measures of Medicaid spending, the states varied dramatically. Although the national average in 1984 stood at precisely 1.0 percent, state spending varied from more than 2.5 percent of income in New York to less than 0.4 percent in Wyoming. Most of the states that spent the largest proportions of their income on Medicaid also showed the highest spending per capita and per poor person. Seven states (Massachusetts, Michigan, Minnesota, New York, Pennsylvania, Rhode Island, and Wisconsin) were above average on all three measures, and five states (Connecticut, Illinois, Ohio, Maine, and Vermont) were above average on two of the three. Similarly, certain states tended to appear at the low end of each of the different measures of Medicaid spending. Six states (Alabama, Florida, Idaho, South Carolina, West Virginia, and Wyoming) appeared among the bottom ten in all three tables; another three states (Nevada, New Mexico, and Utah) were among the bottom ten in two of the three.

Somewhat contrary to our expectations, the share of expenditures paid by the state—determined by the federal matching rate—did not appear to have much influence on the generosity of Medicaid programs. For example, none of the seven "most generous" states and the District just mentioned paid less than a 40 percent share (not including OBRA-mandated reductions in federal matching rates) of the total amount spent under their programs. In contrast, four of the six least generous states, according to these measures,

TABLE 8

MEDICAID SPENDING AS A PERCENTAGE OF STATE INCOME, 1984

State	*Medicaid Expenditures (Thousands of Dollars)*	*State Share (Percent)*[a]	*State Expenditures as a Percentage of State Income*[b]
Total United States	34,456,104	. . .	1.00
New York	6,768,897	50.00	2.55
Minnesota	955,049	47.33	1.59
Rhode Island	236,768	41.83	1.56
Massachusetts	1,327,885	49.87	1.47
Michigan	1,629,307	49.30	1.32
Wisconsin	911,072	43.13	1.31
Ohio	1,626,740	44.56	1.05
Illinois	1,686,655	50.00	1.04
Pennsylvania	1,773,039	43.96	1.03
North Dakota	99,613	38.68	1.03
Louisiana	687,500	35.55	0.99
Connecticut	551,750	50.00	0.98
Maine	207,127	29.37	0.98
Hawaii	132,119	50.00	0.92
South Dakota	89,829	31.69	0.91
Arkansas	341,255	26.35	0.88
Vermont	84,291	30.63	0.88
Iowa	325,332	44.76	0.86
California	3,282,407	50.00	0.86
Maryland	598,540	50.00	0.84
Oklahoma	397,047	41.53	0.84
Kentucky	487,730	29.28	0.80
New Jersey	1,048,126	50.00	0.80
Washington	480,835	50.00	0.79
Montana	96,841	35.59	0.79
Indiana	645,135	40.07	0.78
Delaware	68,209	50.00	0.75
Kansas	238,128	49.33	0.74
Nebraska	149,536	42,87	0.68
Mississippi	312,455	22.37	0.67

TABLE 8 (*Continued*)

State	*Medicaid Expenditures (Thousands of Dollars)*	*State Share (Percent)*[a]	*State Expenditures as a Percentage of State Income*[b]
Colorado	299,828	50.00	0.64
New Hampshire	110,159	40.55	0.64
Tennessee	532,437	29.34	0.64
Texas	1,465,481	45.63	0.64
Missouri	482,276	38.60	0.61
Oregon	233,131	42.88	0.61
Alaska	59,020	50.00	0.60
Georgia	610,388	32.57	0.59
Virginia	514,845	43.47	0.56
North Carolina	610,899	30.46	0.54
New Mexico	132,596	30.61	0.53
Alabama	360,913	27.86	0.50
Nevada	65,803	50.00	0.49
South Carolina	295,055	26.49	0.47
Florida	787,263	41.59	0.45
Idaho	65,959	32.72	0.45
West Virginia	136,890	29.43	0.43
Utah	122,741	29.16	0.41
Wyoming	26,600	50.00	0.39

a. Equal to 100 minus the federal matching percentage. Percentages are not adjusted for reductions resulting from the Omnibus Budget Reconciliation Act.

b. State income equals the total adjusted gross income reported on federal tax returns minus federal income taxes within a state.

had to cover no more than a 33 percent share of their total Medicaid costs. The state with the lowest state share, Mississippi at 22.37 percent, ranked twenty-third on expenditures per capita, forty-fourth on expenditures per person in poverty, and thirtieth on state expenditures as a percent of state income. Apparently, many wealthier states were willing to support generous Medicaid programs even though the cost to the state was relatively high, whereas many poorer states were unwilling to do so, even though their share of the cost would have been relatively low. In other words, under the current set of federal policies matching rates appear to be less important in determining program spending than each state's ability to pay. This means that federal subsidies to poorer states are not sufficient to encourage them to spend on Medicaid at the same level as wealthier states.

Why Do State Expenditures Vary So Greatly?

Past research has attributed the aforementioned differences in state spending levels to a number of factors, including the price paid by the state to purchase medical services (which is partly determined by the matching rate); the proportion of the state population in poverty; the overall wealth of the state; and the general attitude of the state's voters toward welfare. Grannemann (1979), for example, developed a model that argued that the generosity of the program is determined primarily by voters' preferences for Medicaid compared with other public goods and by voters' willingness—or unwillingness—to tax themselves to provide public services. He found that variations in Medicaid benefits across states were mainly a function of recipient needs, the effective price of Medicaid services (including the federal matching rate), taxpayer income, and the availability of providers.

Using more recent data (1979–82), we developed a model that assumed that Medicaid expenditures would depend on factors such as income (ability to pay); price (the federal matching rate); state preferences (willingness to spend state dollars on in-kind welfare programs); the characteristics of the population the program might serve, which affects the demand for services within a state; and the availability of providers, because of their ability to influence policy and their effect on patient access (supply) (Holahan 1984).

Using a set of variables representing these factors, we estimated a series of regression equations explaining state Medicaid spending in total and by type of service (acute and long-term care). The data used in the analysis covered four years (1979–82) for each of forty-nine states and the District of Columbia. We used a set of dummy variables representing time—one variable for each year after 1979—to control for changes in spending across years not associated with the explanatory variables in the equations. Dollar values were deflated to 1979 levels using the gross national product implicit price deflator.

The results of the regressions of these variables on per capita Medicaid spending are presented in table 9.[3] The analysis showed that an increase of 1.0 percent in real income per taxpayer would result in an increase in total spending from 1.2 percent to 1.7 percent.[4] In addition, an increase of 1.0 percent in the federal matching rate was estimated to increase total spending by 1.0 percent to 1.3 percent. The study also found that the response of long-

3. Both linear (additive) and log-linear (multiplicative) models were tested in the analysis. For simplicity, only the log-linear results are presented here. The findings were essentially the same under both models.

4. These impacts are greater than those reported earlier because they are based on a cross-sectional analysis, which yields long-term responses. That is, they reflect the longer-term response to variations in incomes and other factors in terms of their effect on expenditure patterns.

term care spending to both income and federal matching rates was stronger than for acute care.

The results strongly suggest that spending differences are related to state income; that is, the higher the state's income, the greater its ability to pay for Medicaid services. Higher-income states have fewer people in poverty, but the strong relation between the income variable and spending suggests that higher-income states spend more despite lower levels of need. In the analysis, we had difficulty disentangling the effect of income from that of the supply of providers, particularly physicians. The results suggest that the spending levels were higher in states where the physician supply was greater, perhaps because the poor have greater access to physicians where they are in abundance.

The results of the matching rate variable indicate that states with higher federal matching payments have higher levels of spending. Federal matching incentives, which vary inversely with state incomes, have been effective in reducing the extent of interstate variation that would otherwise occur, but higher federal matching rates in low-income states are insufficient to offset reduced ability to pay. The matching formulas as currently structured are insufficient to assure even approximately equal access among states to either acute care or long-term care services for the poor.

Demographic characteristics that proved to be significantly related to Medicaid spending were the percentage of the population that finished high school and the percentage that was nonwhite. The lower the percentage finishing high school, the greater the level of Medicaid acute care spending; a 1.0 percent increase in the percentage of the population finishing high school resulted in a 1.5 percent decrease in acute care expenditures. The greater the percentage of the population of a state that was nonwhite, the greater the overall level of Medicaid spending; this effect was overwhelmingly due to increases in acute care expenditures.

The extent of regional differences unaccounted for by variations in income, federal matching rates, and demographic characteristics was perhaps the most significant finding of the analysis. The results indicated broad differences in political philosophy across the country, that is, in attitudes toward spending on the Medicaid population. Consistently, the South and West showed lower levels of spending than the Midwest (the reference region), and the East had higher levels of spending, all other factors held constant. For example, in the total expenditure equation, the West and South showed per capita spending levels that were approximately 25 and 42 percent lower than the level in the Midwest. At the same time, the East showed a per capita spending level that was 28 percent higher than that in the Midwest. Acute care spending was found to be 40 percent higher in the East than in the

TABLE 9

REGRESSION RESULTS: DETERMINANTS OF STATE MEDICAID EXPENDITURES, BY BROAD SERVICE CATEGORY, 1979–82

	Total Expenditures		*Acute Care Expenditures*		*Long-term Care Expenditures*	
Independent Variable	*Full Model*	*Estimates*[a]	*Full Model*	*Estimates*[a]	*Full Model*	*Estimates*[a]
Intercept	−11.86**	−13.46**	−4.32	−8.31	−8.32	−11.09*
	(−2.18)	(−2.10)	(−0.69)	(−1.17)	(−1.60)	(−1.89)
Real income per taxpayer	1.15**	1.72**	0.55	1.16*	1.02*	1.70**
	(2.08)	(2.72)	(0.88)	(1.65)	(1.86)	(2.80)
Federal matching rate	0.95**	1.31**	0.29	0.90*	0.50	0.84**
	(2.38)	(2.98)	(0.65)	(1.90)	(1.49)	(2.24)
Percent of state population under age 18	−0.91	−1.57†	−0.15	−2.06†	. . .	. . .
	(1.60)	(−2.90)	(−0.24)	(−3.90)	. . .	. . .
Percent of population over age 75	−0.19	−0.02	0.87*	1.57†	−0.26	1.20**
	(−1.63)	(−0.14)	(1.87)	(3.11)	(−0.51)	(2.32)
Percent of state population finishing high school	−0.79**	−0.34	−1.65†	−1.47†	−0.21	0.44
	(−1.96)	(−0.73)	(−3.65)	(−2.88)	(0.44)	(0.82)
Percent of state population nonwhite	0.08**	0.09**	0.16†	0.22†	0.04	0.02
	(2.17)	(2.00)	(3.78)	(4.67)	(0.77)	(0.32)
Percent of state population living in urban area	−0.26*	0.13	−0.26	0.11	0.01	0.04
	(−1.70)	(0.80)	(−1.57)	(0.66)	(−0.03)	(0.22)
Physicians per 10,000 people	0.99†	. . .	1.11†	. . .	. . .	. . .
	(7.07)	. . .	(7.26)	. . .	. . .	. . .
Hospital beds per 10,000 people	−0.05	. . .	0.03	. . .	. . .	. . .
	(−0.37)	. . .	(0.21)	. . .	. . .	. . .

TABLE 9 (Continued)

Independent Variable	Total Expenditures		Acute Care Expenditures		Long-term Care Expenditures	
	Full Model	Estimates[a]	Full Model	Estimates[a]	Full Model	Estimates[a]
Nursing home beds per 1,000 elderly people	0.38†	. . .	. . .	. . .	0.58†	. . .
	(5.68)	. . .	. . .	. . .	(7.15)	. . .
State in eastern region of the United States	0.11	0.28†	0.11	0.40†	0.45†	0.35†
	(1.32)	(3.81)	(1.11)	(4.87)	(6.20)	(4.36)
State in southern region of the United States	−0.30†	−0.42†	−0.32†	−0.35†	−0.07	−0.15
	(−3.32)	(−4.13)	(−2.94)	(−2.98)	(0.68)	(−1.27)
State in western region of the United States	−0.17*	−0.25†	0.02	0.12	−0.20**	−0.27*
	(−1.91)	(−2.76)	(0.23)	(1.12)	(−2.04)	(−2.41)
1980	0.03	0.08	0.04	0.09	0.05	0.06
	(0.66)	(1.26)	(0.67)	(1.31)	(0.88)	(0.88)
1981	0.09	0.19†	0.06	0.17**	0.14*	0.18*
	(1.49)	(2.79)	(0.92)	(2.36)	(2.12)	(2.35)
1982	0.15**	0.26†	0.05	0.19**	0.22**	0.28†
	(2.00)	(3.10)	(0.63)	(2.00)	(2.72)	(3.16)
Summary statistic						
$\bar{R}^2$	0.61	0.46	0.64	0.54	0.50	0.36

SOURCE: John Holahan, "The Effects of the 1981 Omnibus Budget Reconciliation Act on Medicaid," revised working paper (Washington, D.C.: Urban Institute, March 1986). See text for definition of variables. The t-ratios are in parentheses.

a. Estimates for income and federal match, excluding the provider availability variables (physicians per 10,000 beds, hospital beds per 10,000 people, and nursing home beds per 10,000 people).

* Significant at the 0.10 level.
** Significant at the 0.05 level.
† Significant at the 0.01 level.

Midwest, all else held constant, while spending in the South was 35 percent below that in the Midwest. Expenditures on acute care in the West were not significantly different from those in the Midwest.

Some of these expenditure differences, particularly the level of expenditures in the East, seem to be attributable to a much greater supply of physicians. Spending for long-term care was found to be substantially higher (35 percent) in the East than in the Midwest, whereas expenditures in the West were substantially lower (27 percent). Spending levels in the South were not significantly different from those in the Midwest.

The results, then, indicate that substantial variations in state expenditures were due to factors that are not explained by income, federal matching incentives, or demographic characteristics. The variations relate to differences in state markets or preferences with respect to redistribution of income toward the poor. In some regions, states are willing to spend substantially more than can be explained by income alone, and in other regions substantially less.

Medicaid Spending and Interstate Transfers

Tables 6 through 8 demonstrated that many high-income states not only spend more, proportionately, on their low-income populations, but also spend more from their own resources on these populations. In this section we analyze whether higher-spending wealthier states and lower-spending poorer states are actually net gainers or losers from federal matching grants.

To examine the issue of transfers of funds into and out of states, we compared the federal contribution to each state's Medicaid expenditures (the flow back from the federal Treasury into state coffers) with estimates of each state's contribution to federal tax revenues used for Medicaid (the flow out of states into the federal Treasury). State contributions to federal tax revenues used for Medicaid were estimated by taking the ratios of federal income tax payments by each state to total federal income tax revenues multiplied by the total federal contribution to Medicaid. This procedure in effect assumes that other sources of tax revenues, such as corporate income taxes, excise taxes, and estate taxes, are distributed by states in approximately the same way as income taxes. The estimates of state contributions will be in error to the extent that these other revenue sources are distributed differently.

The results are shown in table 10, which compares the federal contribution to each state's Medicaid spending with the state income tax contributions to federal Medicaid spending. The ratios in the third column indicate whether states are net gainers or net losers. Ratios in excess of 1.0 indicate the state receives more than it contributes, while ratios less than 1.0 indicate the opposite. The estimates show that there are substantial redistribution

TABLE 10

FEDERAL SHARE OF MEDICAID SPENDING, 1984

State	*Federal Contributions to Medicaid Spending (Millions of Dollars)*[a]	*State Income Tax Contributions to Federal Medicaid Spending (Millions of Dollars)*	*Ratio*
Total United States	18,724.0	18,724.0	. . .
Maine	143.8	65.8	2.19
New York	3,380.3	1,577.1	2.14
Arkansas	240.5	118.4	2.03
District of Columbia	138.7	69.6	2.00
Rhode Island	135.1	69.6	1.94
Vermont	59.4	32.0	1.86
Mississippi	233.4	125.9	1.85
South Dakota	59.1	37.6	1.57
Kentucky	341.0	218.0	1.56
Wisconsin	509.6	334.6	1.52
Minnesota	474.3	312.0	1.52
Massachusetts	689.7	537.6	1.28
Tennessee	364.7	295.1	1.24
South Carolina	214.3	174.8	1.23
Louisiana	427.8	349.6	1.22
North Dakota	57.2	47.0	1.22
Michigan	831.8	703.0	1.18
Alabama	251.8	219.9	1.14
Montana	58.4	52.6	1.11
North Carolina	396.6	360.9	1.10
Ohio	878.9	836.5	1.05
Georgia	390.1	372.2	1.05
Pennsylvania	962.9	928.6	1.04
New Mexico	90.5	88.3	1.02
Utah	85.3	86.5	0.99
Indiana	361.2	404.1	0.89
Hawaii	65.5	75.2	0.87
Idaho	43.0	50.8	0.85
California	1,830.8	2,180.5	0.84
Oklahoma	227.4	276.3	0.82

TABLE 10 (*Continued*)

State	*Federal Contributions to Medicaid Spending (Millions of Dollars)*[a]	*State Income Tax Contributions to Federal Medicaid Spending (Millions of Dollars)*	*Ratio*
Iowa	167.7	206.8	0.81
New Hampshire	64.2	80.8	0.79
West Virginia	95.7	122.2	0.78
Missouri	290.5	374.1	0.78
Illinois	821.0	1,065.8	0.77
Nebraska	85.1	114.7	0.74
Oregon	128.2	174.8	0.73
Maryland	289.9	415.4	0.70
Connecticut	259.3	379.7	0.68
Delaware	32.4	52.6	0.62
Washington	233.4	375.9	0.62
New Jersey	504.4	821.4	0.61
Virginia	279.6	458.7	0.61
Kansas	118.3	203.0	0.58
Colorado	147.5	291.4	0.51
Florida	447.7	883.5	0.51
Texas	744.3	1,501.9	0.50
Alaska	29.3	71.4	0.41
Nevada	30.1	80.8	0.37
Wyoming	12.4	48.9	0.25

a. Federal contributions to Medicaid spending were derived by multiplying the federal matching percentage for each state by 1984 Medicaid expenditures.

b. State tax contributions were derived by obtaining the most recent proportion of federal income tax revenues from each state and multiplying that proportion by the total federal share of 1984 expenditures. See Internal Revenue Service, individual income tax returns, *1982 Statistics on Income*, Publication 79 (10-84) (Washington, D.C.: U.S. Government Printing Office, 1982).

effects among states. New York, for example, receives $2.14 from federal matching funds for every $1.00 it contributes, whereas Texas receives only $0.50 for every $1.00 it contributes. In general, states with generous programs (New York, Massachusetts) or with a large proportion of poor people (Arkansas, Mississippi) tend to be net gainers. In the former case, broad coverage of population and services results in high federal matching contributions that exceed even relatively high contributions by state taxpayers. In the second case, although program policies may not be particularly generous, high poverty rates combined with low per capita incomes make the federal share of spending large; at the same time, tax payments are relatively small because

of low incomes. In contrast, states with either stringent program policies (Texas, Florida) or few poor persons (Connecticut, Washington) coupled with moderate or high tax burdens tend to be net losers.

Summary

In this chapter we present data analyzing changes in Medicaid spending between 1978 and 1984 and variations across states in levels of expenditures. The most important findings are as follows:

Medicaid growth rates dropped substantially in real terms after 1981. Spending growth had averaged 5.3 percent a year in constant dollars before 1981, but stayed constant in the three years thereafter. Spending declined more for acute care services than for long-term care. Spending growth in constant dollars averaged 4.2 percent a year between 1978 and 1981 and 1.0 percent a year thereafter. In contrast, real growth in spending for long-term care fell from an average rate of 6.6 percent a year to 4.4 percent after 1981. Finally, expenditures fell more (about 3 percent a year) for adults between the ages of twenty-one and sixty-five and children after 1981 than for aged or disabled people (for whom expenditures actually increased by 1.0 percent a year).

The drop in the growth rate of Medicaid expenditures was due in part to the decline in states' ability to pay, which was attributable directly to the severe economic recession of 1982. The decline in ability to pay offset the effect on expenditures of the increase in persons in need. A second factor was the reduction in federal matching rates legislated in OBRA. Finally, the 1981–84 period saw an end to a long-term upward growth trend unrelated to income or other factors.

Medicaid expenditures are likely to increase in real terms after 1984, but it is unlikely that spending growth will return to the rates experienced before 1981. Real income is projected to increase, which will result in increases in Medicaid spending. The OBRA legislative reductions in federal matching rates ended in fiscal 1985, so real Medicaid spending is expected to increase thereafter. Finally, long-term factors, such as broadened coverage of pregnant women and children and increased aging of the population, should result in more financial pressure on state Medicaid programs.

Expenditures per capita varied by a factor of about 8 between the highest- and the lowest-spending states. These variations existed for both acute and long-term care services. Some of the variation is explained by differences in state per capita income. Greater ability to pay resulted in greater willingness to spend on Medicaid services despite lower levels of need in those states. Higher levels of income were also associated with greater availability of

medical care providers, which facilitates access of the Medicaid-covered poor to the medical care system. Federal matching rates, although inversely related to state per capita income, were insufficient to offset variations in states' ability to pay. Finally, there were broad regional differences in willingness to spend on Medicaid services.

Variations in spending result in a great redistribution of dollars among states. In some more affluent states, broad coverage of population and services results in high federal contributions that exceed even relatively high tax payments from state taxpayers to the federal government. In some states with large poor populations, there are relatively large numbers of recipients in absolute terms while at the same time low per capita incomes result in high federal matching contributions. Moreover, tax payments to the federal government are low because of low incomes. On the other hand, states that have either small poverty populations or stringent program policies and moderate to high tax burdens are net losers.

CHAPTER 3

ELIGIBILITY

Since the inception of the Medicaid program, eligibility for benefits has been linked to receipt of cash assistance under either the Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) programs. These welfare programs serve populations whose financial resources fall below some (variously defined) standard and who meet other "categorical" criteria. The AFDC category consists of families with at least one dependent child who has been deprived of parental support because of the death, disability, continued absence, or, at state option, unemployment, of one of the parents; the SSI category consists of the aged (people aged sixty-five or older), blind, or disabled people. The linking of Medicaid eligibility with welfare status, which has been the subject of much controversy throughout the program's history, appears to have been as much a product of historical precedent as of deliberate program design. Before 1965, the federal government had provided state welfare programs with limited matching funds for medical assistance. The linking of Medicaid eligibility to welfare status was continued to avoid duplicative processes of eligibility determination; the assumption was that the population most in need of Medicaid services would in fact be receiving cash assistance.

Although Medicaid coverage of persons in AFDC-recipient families is federally mandated for all states, the states have considerable discretion concerning AFDC eligibility criteria. The result has been that Medicaid eligibility varies widely from state to state. Categorically eligible families are financially eligible for cash assistance and thus also Medicaid if their income and resources fall below a payment standard set by the state. In 1984, the AFDC payment standard for a family of four ranged from $775 per month in Alaska to $120 per month in Mississippi; the national poverty level for a family of four was $848 per month. In addition to differing greatly among states, AFDC

payment standards have in general not risen with inflation. The Congressional Budget Office (1985) recently reported, for example, that maximum AFDC benefits fell in real terms by 33 percent between 1970 and 1985. This had the effect of reducing eligibility of those with small amounts of earned income. Obviously, having an income below the poverty line does not guarantee Medicaid coverage to a family with dependent children. States can, however, choose eligibility options (discussed below) that allow coverage of families and individuals with incomes above the payment standards. States can also choose certain options permitting coverage of people not meeting categorical requirements.

The relation between the SSI program and Medicaid coverage is more complicated than is the case with AFDC. Originally established to consolidate diverse federal-state cash assistance programs into a national program guaranteeing a minimum income for poor aged, blind, or disabled people, SSI is mainly a system of federally administered cash grants with its own nationally uniform eligibility criteria. Because these uniform eligibility criteria, if extended automatically to Medicaid, might have resulted in substantial expansions of some state Medicaid programs, the federal government permitted states to establish criteria that were more restrictive than the federal SSI ones for the Medicaid eligibility of SSI cash recipients. The criteria can be more restrictive in setting financial requirements for income or resources or in defining blindness or disability. (These criteria cannot, however, be more restrictive than the criteria used by a state for administering aid to aged, blind, and disabled people before the advent of SSI in 1972.) If states choose more restrictive criteria (usually, when chosen, in the financial area), they are required to allow the "restricted" persons to use what is called a "spend down," which simply means that the medical expenses these people incur are subtracted from their income before their income eligibility is determined.

Federal statute allows states a number of options for extending Medicaid coverage to other groups. States can, for example, cover people who are eligible for cash assistance but not receiving it because they have not applied, and persons who would be eligible for cash assistance if they were not institutionalized. States can also cover the so-called Ribicoff kids, that is, children who meet financial eligibility requirements but not other categorical ones—who live, for example, in two-parent families or in foster homes. By far the largest single optional group, however, is the "medically needy"—families and individuals who have incomes or resources too high to be financially eligible for cash assistance but who are categorically eligible and are deemed unable to pay for necessary medical care. Medically needy coverage can be extended to people whose incomes are below a state-established

standard or would fall below that standard with payment of their medical expenses.[1]

Recent Legislative Changes

The cost-cutting pressures discussed in the preceding chapter have led to a number of legislative changes that, although directed at welfare eligibility, have significantly altered Medicaid eligibility policies as well. Among the most important of these changes were those contained in the Omnibus Budget Reconciliation Act of 1981 (OBRA) aimed at limiting AFDC eligibility for families with earned income. OBRA limited gross income eligibility to 150 percent of the standard of need established by each state (which is separate from and in many cases higher than the state's payment standard). (The "need standard" represents a state's calculation of the minimally adequate income for a family of any given size. It has no legal bearing on what a state chooses to pay.) OBRA also limited various income disregards—for child care and work-related expenses and for specified amounts of earned income—used in determining eligibility. In addition, OBRA did the following.

- Prohibited AFDC cash payments to otherwise childless pregnant women before the sixth month of pregnancy; beginning with the sixth month, AFDC coverage was allowed at the states' option. Medicaid coverage beginning from the time the pregnancy was medically verified remained a state option.
- Made coverage optional rather than mandatory for persons under age twenty-one who do not receive AFDC payments but who would be eligible for AFDC if they were in school.
- Allowed income and asset levels for the medically needy to vary between groups (that is, the elderly versus the disabled), thus permitting states more freedom to target optional Medicaid coverage.

A number of states made changes in their eligibility rules in response to OBRA (Hill 1984). Sixteen states substantially raised their need standards without making corresponding changes in their payment standards, thus effectively nullifying the limit on income mandated by OBRA without greatly affecting eligibility for the program. (As already noted, the need standards

1. Medically needy income standards are set by the states within a federally prescribed range: the minimum level is the payment standard (which varies according to family size) generally used in a state's AFDC or SSI programs; and the maximum level is 133 percent of the state's actual AFDC payments.

are virtually irrelevant to whether a person qualifies for cash assistance.) In response to the increased flexibility in operating medically needy programs, only one state (Tennessee) dropped coverage for a significant group of eligibles (elderly, blind, and disabled people), while several states (Florida, Georgia, Iowa, Mississippi, Oregon, and South Carolina) developed medically needy programs for pregnant women and children. OBRA's prohibition against cash payments to childless pregnant women had little effect on Medicaid coverage, because most states providing cash payments also had provisions for covering these women under the Medicaid-only option. Only two states, Delaware and Louisiana, did not have Medicaid only coverage as an alternative. In response to OBRA's provisions relating to coverage of people aged eighteen to twenty-one, eighteen states lowered their age limit to below twenty-one for coverage of "Ribicoff" children, and thirty-two states eliminated coverage of people aged eighteen to twenty-one who would have been eligible for AFDC if they had been under age eighteen or in school.

A second set of eligibility changes was enacted in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), but unlike OBRA, TEFRA had a comparatively minor effect on Medicaid. The most important Medicaid provisions of the legislation were the following.

- Allowed states to place liens on the real property of institutionalized Medicaid recipients expected to remain in the institution permanently, and to deny eligibility to persons who dispose of their homes for less than market value within twenty-four months of applying for Medicaid.
- Allowed states to waive deeming rules (such as considering parents' income and assets available to pay for medical care) so certain disabled children could retain Medicaid eligibility outside institutions. This provision would apply to children who, under existing rules, would have been eligible only while remaining institutionalized, even though care could be provided at less or no greater cost at home.[2]

Forty-five states adopted policies restricting eligibility for persons who dispose of their assets only to qualify for Medicaid, and eleven states adopted "Katie Beckett" provisions to allow for coverage of disabled children outside institutions (Hill 1984).

In 1984, the Deficit Reduction Act (DEFRA) contained several provisions designed to expand Medicaid eligibility and reverse some of the AFDC eligibility tightening that occurred under OBRA. DEFRA, for example, in-

2. This provision came to be known as the "Katie Beckett" waiver, named after the little girl whose televised plight was influential in its passage.

creased the eligibility limit on gross income to 185 percent of a state's need standard and loosened the limits OBRA had placed on earned income disregards. It also provided for a nine-month transition period of Medicaid coverage—with an optional additional six-month extension—for families losing AFDC cash benefits because of OBRA's limits on the disregard of earned income. DEFRA also did the following.

- Required Medicaid coverage of first-time pregnant women who would be eligible for AFDC if the child were already born, and pregnant women in financially eligible two-parent families in which the principal wage earner is unemployed.
- Required Medicaid coverage for children up to age five in financially eligible two-parent families (applicable only to children born on or after October 1, 1983).

Before DEFRA, seven states did not cover childless pregnant women who would be eligible for AFDC if the child had already been born, twenty-one states did not cover such women in AFDC unemployed parent families, and twenty-eight states did not cover all childen under age five (Hill 1984).

In the most recent legislative action, the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 extended Medicaid coverage to all pregnant women if they meet the state's financial eligibility criteria. In addition, it allowed states to cover non-AFDC children up to age five, again providing they meet the state's financial eligibility criteria.

Medicaid Eligibility Data

In 1984 the Medicaid program paid for medical care services for 20.1 million persons; AFDC children accounted for slightly less than half of the total, AFDC adults for approximately one-quarter, aged persons for approximately 15 percent, and blind and disabled persons for slightly less than that amount (14 percent). In terms of expenditures, the distribution by recipient category is almost reversed: children accounted for only about 12 percent of all expenditures and the aged, for more than 40 percent. Together, the AFDC categories—adults and children—accounted for nearly three-quarters of the recipients but only one-quarter of the spending. In contrast, the SSI categories—aged and blind and disabled—accounted for only about one-quarter of recipients but three-quarters of program spending. This spending distribution reflects the SSI population's need for more frequent and more intensive medical care; it may also reflect state preferences for using Medicaid to cover long-term rather than acute care.

Variation among States

As already noted, the latitude given states in designing their Medicaid programs has resulted in dramatic variations in coverage across states. In 1984 the ratio of Medicaid recipients to state population varied by more than a factor of four, ranging from 0.03 in Wyoming to 0.13 in California (the first column in table 11). Looking across age categories, cross-state variations in coverage appear to be greatest for children and least for the aged. Coverage of adults ages twenty-one to sixty-five is substantially lower in general than coverage for the younger and older age groups, but it also varies widely by state.

As is also suggested by table 11, the size of the potentially eligible population within a state does not appear to be a critical factor in determining the breadth of its Medicaid coverage. Although several of the states with relatively high poverty populations also show high ratios of Medicaid recipients to state population (for example, Kentucky and Mississippi), a number of others do not (such as Florida, South Dakota, and Texas). In addition, several states with relatively small poverty populations rank high on their ratio of Medicaid recipients per capita (such as California, Michigan, Rhode Island, and Wisconsin).

In an effort to separate state policy choices from demographic factors, we compared data on the ratio of Medicaid recipients to persons in poverty across states (table 12). These data are for 1979, which is the most recent year for which reliable poverty figures are available for all the states. Although not all Medicaid recipients have incomes below poverty level and Medicaid is not designed to cover all persons in poverty, low income is one of the criteria for eligibility under the program. Thus, the ratio of Medicaid recipients to persons in poverty in a state should be generally indicative of how broad Medicaid coverage is within that state. States with ratios greater than 1.00 are obviously covering a population at least equal in size, though not identical, to their populations in poverty, whereas states with ratios lower than 0.50 could not be covering even the majority of their poor under Medicaid. Table 12 illustrates the large cross-state variation that exists in Medicaid coverage of the nation's poor. Eight states had ratios greater than 1.00 and 18 had ratios lower than 0.50. The clear implication is that state policy preferences are far more important than the relative magnitude of a state's poverty population in determining Medicaid coverage. These preferences are reflected in very different decisions on income standards and coverage of optional groups and are ultimately reflected in the numbers we have presented.

TABLE 11

RATIOS OF MEDICAID RECIPIENTS TO STATE POPULATION, BY AGE GROUP, 1984

State	*Ratio of Medicaid Recipients to State Population*	*Ratio of Elderly Recipients to Population over Age 65*	*Ratio of Adult Recipients to Population Aged 21 to 65*	*Ratio of Child Recipients to Population under Age 21*
Total United States	0.09	0.11	0.04	0.14
California	0.13	0.18	0.06	0.20
Michigan	0.13	0.09	0.07	0.24
Kentucky	0.13	0.16	0.07	0.17
New York	0.12	0.16	0.05	0.22
Rhode Island	0.12	0.18	0.05	0.16
Mississippi	0.12	0.22	0.03	0.14
Maine	0.11	0.13	0.05	0.17
Wisconsin	0.10	0.12	0.06	0.19
Vermont	0.10	0.12	0.05	0.14
Massachusetts	0.10	0.18	0.04	0.14
West Virginia	0.10	0.09	0.05	0.14
Ohio	0.09	0.07	0.06	0.16
Hawaii	0.09	0.13	0.05	0.15
Illinois	0.09	0.06	0.04	0.15
Pennsylvania	0.09	0.07	0.05	0.17
Louisiana	0.09	0.20	0.03	0.10
Arkansas	0.08	0.16	0.02	0.09
Minnesota	0.08	0.10	0.04	0.12
New Jersey	0.08	0.07	0.04	0.15
Alabama	0.08	0.18	0.03	0.09
Delaware	0.08	0.07	0.03	0.14
Oklahoma	0.08	0.14	0.03	0.11
Georgia	0.08	0.16	0.03	0.09
Maryland	0.07	0.09	0.03	0.13
Tennessee	0.07	0.13	0.02	0.09
Missouri	0.07	0.10	0.03	0.10
South Carolina	0.07	0.14	0.04	0.11
Connecticut	0.07	0.08	0.03	0.12
Washington	0.07	0.09	0.03	0.12
Iowa	0.07	0.07	0.04	0.11

TABLE 11 (*Continued*)

State	*Ratio of Medicaid Recipients to State Population*	*Ratio of Elderly Recipients to Population over Age 65*	*Ratio of Adult Recipients to Population Aged 21 to 65*	*Ratio of Child Recipients to Population under Age 21*
Kansas	0.06	0.07	0.03	0.11
New Mexico	0.06	0.09	0.02	0.07
Montana	0.06	0.11	0.04	0.11
North Carolina	0.06	0.09	0.02	0.08
Nebraska	0.05	0.07	0.03	0.08
Virginia	0.05	0.10	0.02	0.08
Oregon	0.05	0.06	0.02	0.08
Florida	0.05	0.06	0.02	0.08
Indiana	0.05	0.06	0.02	0.07
North Dakota	0.05	0.10	0.02	0.07
Colorado	0.05	0.13	0.02	0.08
Alaska	0.05	0.16	0.02	0.07
South Dakota	0.05	0.08	0.02	0.05
Texas	0.04	0.15	0.02	0.05
Utah	0.04	0.05	0.03	0.06
New Hampshire	0.04	0.08	0.03	0.05
Idaho	0.04	0.05	0.01	0.05
Nevada	0.03	0.07	0.01	0.04
Wyoming	0.03	0.06	0.02	0.04

SOURCES: Same as table 1 and U.S. Bureau of the Census, "Estimates of the Population of the United States, by Age, Sex and Race: 1980 to 1984" (Washington, D.C.: U.S. Government Printing Office, 1984), and "1980 Census of Population: General Social and Economic Characteristics, United States Summary" (Washington, D.C.: U.S. Government Printing Office, 1984).

Changes over Time

As shown in table 13, between 1978 and 1984 the total number of Medicaid recipients remained essentially constant, with annual percentage changes averaging less than 1 percent. The number of recipients in 1984 was actually slightly lower than in 1978, having declined modestly between 1981 and 1984. This trend is consistent with the trend since the mid-1970s; the number of Medicaid recipients in 1978 was essentially unchanged from 1975, having peaked in 1977 after an increase of approximately 3 percent over the 1975 level (HCFA 1984b).

These numbers suggest that the Medicaid program did not function as might have been expected during the severe recession of the early 1980s.

TABLE 12

RATIOS OF MEDICAID RECIPIENTS TO PEOPLE IN POVERTY, 1979[a]

State	*Ratio of Medicaid Recipients to People in Poverty*	*Percentage of Population in Poverty*
Total United States	0.74	12.4
Massachusetts	1.57	9.6
Rhode Island	1.31	10.3
California	1.28	11.4
Hawaii	1.20	9.9
Pennsylvania	1.15	10.5
Maine	1.11	13.0
Wisconsin	1.06	8.7
New York	1.03	13.4
New Jersey	0.96	9.5
Michigan	0.95	10.4
Connecticut	0.91	8.0
Vermont	0.83	12.1
Illinois	0.83	11.0
Oregon	0.82	10.7
Minnesota	0.81	9.5
Ohio	0.75	10.3
Maryland	0.73	9.8
West Virginia	0.72	15.0
Washington	0.69	9.8
Oklahoma	0.65	13.4
Delaware	0.65	11.9
Kentucky	0.65	17.6
Kansas	0.65	10.1
Iowa	0.59	10.1
New Hampshire	0.58	8.5
Missouri	0.58	12.2
Colorado	0.53	10.1
Louisiana	0.51	18.6
Virginia	0.51	11.8
Arkansas	0.50	19.0
South Carolina	0.50	16.6
Mississippi	0.47	23.9
North Carolina	0.46	14.8
Alabama	0.46	18.9
Georgia	0.45	16.6

TABLE 12 (*Continued*)

State	*Ratio of Medicaid Recipients to People in Poverty*	*Percentage of Population in Poverty*
Utah	0.45	10.3
Montana	0.44	12.3
Tennessee	0.44	16.5
Indiana	0.44	9.7
Nebraska	0.42	10.7
Alaska	0.42	10.7
New Mexico	0.38	17.6
North Dakota	0.36	12.6
Idaho	0.35	12.6
Florida	0.34	13.5
Texas	0.33	14.7
Nevada	0.32	8.7
South Dakota	0.31	16.9
Wyoming	0.31	7.9

SOURCES: Same as table 11.

a. The poverty data here are taken from the 1980 census, the most recent year for which poverty data are available for all states.

Census Bureau statistics show that the number of people in poverty nationally increased by 35 percent between 1980 and 1984. Thus, at the same time the poor population was increasing, and thus also, ostensibly, the pool of persons from which Medicaid recipients are drawn, the number of actual Medicaid recipients declined. Some of this decline was apparently a response to the eligibility changes enacted in OBRA (Cromwell et al. 1984). Much of it was also probably a result of the failure of AFDC income eligibility standards to keep pace with inflation.

An examination of Medicaid program data over the 1980–84 period suggests that in terms of coverage the aged fared better than other recipient groups. As indicated in table 14, the number of elderly recipients declined fairly steadily over the period. The rate of decline in number of elderly recipients, however, was much less than the rate of decline in the number of poor elderly people between 1980 and 1984 (table 15). In other words, for the aged the Medicaid program was in some way tracking the economic fortunes of the pool of potential recipients—something the program emphatically did not do for AFDC adults and children.

As shown in table 14, the absolute number of AFDC adult recipients grew each year, but the growth in recipients (12.4 percent) was dwarfed by

TABLE 13.

TOTAL U.S. MEDICAID RECIPIENTS AND PERCENTAGE CHANGE, 1978–84

Year or Period	*Number of Recipients (Thousands)*	*Percentage Change from Previous Year*
1978	20,455	
1979	20,072	−1.9
1980	20,205	0.7
1981	20,520	1.6
1982	20,150	−1.8
1983	19,936	−1.1
1984	20,068	0.7
Average annual percentage change		
1978–81	0.1	
1981–84	−0.7	
1978–84	−0.6	

the growth in the number of adults in poverty (22.3 percent shown in table 15). For children, the contrasts are even starker. In both 1982 and 1983, the number of AFDC child recipients declined, by 0.3 and 2.4 percent respectively, and by 1984 the number was only 2.8 percent higher than it had been in 1980. Yet over that same 1980–84 period, the number of children in poverty increased by more than 16 percent. In summary, the number of adult and child Medicaid recipients changed surprisingly little after 1980, despite substantial changes in the pool of potential recipients.

In addition to examining unduplicated recipient counts from HCFA 2082 reports, we examined Medicaid coverage data from the Census Bureau's *Current Population Survey* (CPS). The numbers of individuals covered by Medicaid as reported in the CPS differ from the HCFA numbers for several reasons. The primary difference between the two sets of data is that the HCFA numbers include institutionalized people (such as those residing in nursing homes) while the CPS numbers do not. Consequently, the HCFA recipient counts should be higher than the CPS counts of persons covered by the program. Another difference is that the age classification for children is somewhat different between the two. The HCFA reporting forms classify children as people under age twenty-one; the CPS report from which these data were taken groups children such that they could be separated only into

TABLE 14

MEDICAID RECIPIENTS BY ELIGIBILITY CATEGORY, 1980–84[a]

Category and Year or Period	*Recipients (Thousands)*	*Percentage Change from Pervious Year*	*Average Annual Percentage Change, 1980–84*
Elderly[b]			
1980	3,439	. . .	
1981	3,366	−2.1	
1982	3,238	−3.8	−8.3
1983	3,246	0.2	
1984	3,153	−2.9	
Blind and disabled			
1980	2,874	. . .	
1981	2,914	1.4	
1982	2,838	−2.6	−0.5
1983	2,856	0.6	
1984	2,861	0.2	
AFDC adults[b]			
1980	4,585	. . .	
1981	4,879	6.4	
1982	5,023	3.0	12.4
1983	5,138	2.3	
1984	5,155	0.3	
AFDC children[b]			
1980	9,762	. . .	
1981	9,959	2.0	
1982	9,931	−0.3	2.8
1983	9,692	−2.4	
1984	10,040	3.6	

a. The numbers here reflect some duplication because a person may appear in more than one eligibility category if that person was classified under more than one category in a year, and may appear more than once in the same category if that person went on and off the program more than once a year. We have no reason to believe, however, that this duplication produces any large systematic distortion.

b. Elderly are defined as people aged 65 and over; AFDC adults, aged 21 to 64; and AFDC children, aged under 21.

a category including those under age eighteen. This means that the HCFA groups include fewer adults and more children than they would have under the CPS age classifications. Finally, the HCFA data represent unduplicated

TABLE 15

NUMBER OF MEDICAID ENROLLEES AND PEOPLE IN POVERTY, BY AGE GROUP, 1980–84[a]

Category and Year or Period	*Medicaid Enrollees (Millions)*	*People in Poverty (Millions)*	*Ratio of Medicaid Enrollees to People in Poverty*	*Percentage Change, 1980–84*		*Change in Ratio of Enrollees to People in Poverty*
				Medicaid Enrollees	*People in Poverty*	
Elderly[b]						
1980	3.0	3.8	78.8			
1981	3.1	3.8	80.3			
1982	2.8	3.6	77.4	−6.8	−15.5	8.1
1983	2.9	3.6	79.7			
1984	2.8	3.2	86.9			
Adults[b]						
1980	8.0	13.3	60.5			
1981	8.2	14.9	55.0			
1982	7.9	16.3	48.4	3.9	22.3	−9.1
1983	8.2	17.1	48.2			
1984	8.4	16.3	51.4			
Children[b]						
1980	7.9	11.3	70.0			
1981	8.1	12.2	66.6			
1982	8.2	13.4	61.2	3.6	16.6	−7.9
1983	8.2	13.6	60.7			
1984	8.2	13.1	62.1			
Totals						
1980	19.1	28.4	66.8			
1981	19.4	30.1	62.7			
1982	18.9	33.4	56.7	2.0	14.9	−7.6
1983	19.3	34.2	56.5			
1984	19.4	32.7	59.2			

SOURCE: U.S. Bureau of the Census, "Characteristics of Households and Persons Receiving Selected Noncash Benefits," *Current Population Reports*, series P-60 (Washington, D.C.: U.S. Government Printing Office, selected years). Totals may not add due to rounding.

a. Enrollees are people who are eligible for benefits because they satisfy legislative requirements for eligibility and sign up for the program. Recipients are the enrollees who actually make use of services sometime during the course of a year.

b. Elderly are defined as people aged 65 and over; adults, aged 18 to 64; children, aged under 18.

counts of the number of people who actually used services, while the CPS data represent persons covered irrespective of their actual use. The difference between users and people covered but not using services also accounts for some of the discrepancy between the two sets of numbers.

Two other facts about the CPS data should also be noted. First, the survey asks respondents about their income and Medicaid coverage over the entire previous year, which means that an individual could have been Medicaid covered even if his annual income was higher than the Medicaid eligibility standards. This situation can occur because Medicaid eligibility is based on income over a period substantially less than a full year; thus, an individual could have a low enough income, or high enough medical expenses, at some time during a year to be Medicaid eligible over that period but have a non-poverty-level annual income. Second, income as defined in the data presented here includes transfer income, for example SSI and AFDC payments, which makes the respondents' income higher than would be the case in the absence of those programs. The result is to understate the number of people in poverty compared to what it would be if transfer income was not included.

The CPS data on Medicaid enrollees (persons covered by the program) are presented in table 15. As the data illustrate, the experience of the aged over the 1980–84 period was very different from the experience of adults and children. Consistent with the HCFA 2082 recipient counts, the number of aged Medicaid enrollees according to the CPS declined throughout the period, by a total of 6.8 percent. The number of aged persons in poverty declined by an even greater proportion (15.5 percent), however, with the result that the ratio of enrollees to persons in poverty actually increased.

In contrast, although the number of adults and children covered by the program increased between 1980 and 1984, by 3.9 and 3.6 percent, respectively, the number of adults and children in poverty increased so much faster (by 22.3 and 16.6 percent altogether) that the coverage ratios fell significantly for both groups. Thus, coverage deteriorated for adults and children throughout the economically difficult years of the early 1980s, and in 1984 rebounded only slightly as the number of people in poverty declined.

The decline in coverage for adults and children indicated in the CPS data is likely the result of two different factors. The first is the eligibility changes enacted in OBRA. Although they were primarily directed at AFDC cash assistance eligibility, the link between AFDC and Medicaid would have produced a similar effect, tightened eligibility, in both programs. Previous research suggests that OBRA was associated with declines in Medicaid coverage, at least between 1981 and 1982 (Cohen and Holahan 1984; Cromwell et al. 1984). It is unlikely, however, that OBRA changes alone were responsible for the entire decline in coverage between 1980 and 1984, partic-

ularly in light of how a number of states reacted to the AFDC gross income limits, and later legislative changes that softened the impact of OBRA. The failure of states to increase AFDC payment levels to account for increases in the cost of living also produced de facto eligibility cutbacks over this period. These de facto cutbacks are likely to have been even more important than OBRA in constraining Medicaid coverage over this period.

One final point emerges from an examination of CPS data on Medicaid coverage that has perhaps even greater implications for the program as a whole than the coverage decline just discussed. That is that the coverage ratios presented in table 15 appear to be overestimates of the extent to which Medicaid is available to the poor. The most recent CPS data indicate that only approximately one-third of poor aged and adult individuals and slightly less than one-half of all poor children are actually enrolled in the Medicaid program (U.S. Bureau of the Census 1985). The low coverage ratios for this population are masked in the data just presented by the inclusion in persons covered of those with annual incomes higher than poverty level, for example, because of the inclusion of transfer payments in their income or because their eligibility resulted from high medical expenses rather than low income. When the poverty population is considered by itself, however, the data suggest that access to medical care may still be a serious problem for the noninstituionalized poor.

The Combined Impact of Changes in Eligibility and Service Policies

Although the changes in eligibility policies that have been discussed appear to explain much of the overall decline in Medicaid coverage over the post-1981 years, they by no means account for all the changes in access to program resources that various eligibility groups experienced during this period. Because each of the eligibility groups uses a different mix of services, policy changes designed to affect the use of particular services—the subject of the next two chapters—also affect particular groups differently. Thus, for example, the OBRA-mandated easing of restrictions on home health care (discussed in chapter 5) was much more important to the elderly than to the other groups, because the elderly use this service more intensively. Similarly, the curbs on dental care (discussed in chapter 4) affected AFDC children most strongly, although these curbs resulted in real declines in expenditures for the service for all population groups.

In an effort to sort out the impact of these changes in service policies on the various eligibility groups, we examined changes in expenditures for

each group over the pre- and post-OBRA periods. Table 16 provides a summary of aggregate expenditure changes in spending by eligibility group. (See appendix B at the end of the book for tabulated summaries of the data by type of service.) Expenditure changes by type of service are examined in much more detail in the following chapters; here we want to summarize and highlight the differential impact of the changes on the various eligibility groups. We found, in general, that the growth in expenditures over both periods was most rapid for the blind and disabled, followed by the elderly, and that these more rapid growth rates were entirely attributable to real increases in particular services, and not to changes in numbers of recipients or in inflation rates. That is, the blind and disabled and the elderly continue in general to make more intensive use of the more expensive services than do people in the AFDC categories.

Before 1981, expenditures for the blind and disabled increased by 19.8 percent per year; for the elderly, by 17.3 percent; for AFDC adults, by 13.8 percent; and for AFDC children, by 8.7 percent. Between 1981 and 1984, expenditures grew by 8.7 percent a year for the blind and disabled; by 8.2 percent for the elderly; by 5.2 percent for adults; and by 5.0 percent for children. At the same time, however, real expenditures per recipient fell by 3.1 percent for children and by 4.8 percent for adults, compared with increases of 3.1 percent and 1.8 percent for the elderly and the blind and the disabled, respectively.

The many differences in service utilization among the eligibility groups may account for these differences in spending patterns. For the elderly, the relatively high rate of growth in overall expenditures after 1981 is attributable to some combination of (1) increases in the number of recipients for particular services, (2) exceptional increases in nominal expenditures for particular services, and (3) high real rates of growth for particular services. Expenditures for hospital inpatient care, hospital outpatient services, and home health care registered especially strong growth, increasing by 14.9, 15.1, and 20.3 percent a year, respectively. Moreover, nursing home care—by far the largest expenditure item for the elderly—increased by 7.6 percent a year and prescription drugs increased by 7.3 percent a year.

The number of users of hospital outpatient services, "other" (principally rehabilitative) services, home health care, and nursing home care all increased. In addition, real rates of growth in spending per recipient (after inflation) for particular services increased. The increase in hospital inpatient care (7.8 percent a year between 1981 and 1984) was particularly striking, contrasting starkly with the absence of real growth in the spending for AFDC populations. The growth probably reflects an increase in the Medicare hospital deductible, occasioned by declining lengths of stay and increases in cost per day in U.S.

TABLE 16

CHANGE IN MEDICAID EXPENDITURES DUE TO CHANGE IN RECIPIENTS AND EXPENDITURES PER RECIPIENT, BY ELIGIBILITY CATEGORY, 1978–84[a]

Year or Period	Elderly			Blind and Disabled		
	Recipients (Thousands)	Expenditures per Recipient		Recipients (Thousands)	Expenditures per Recipient	
		Nominal	Constant		Nominal	Constant
1978	3,362	1,878	1,878	2,676	2,075	2,075
1979	3,363	2,128	1,952	2,714	2,484	2,276
1980	3,439	2,550	2,126	2,874	2,663	2,207
1981	3,366	3,008	2,270	2,914	3,294	2,463
1982	3,238	3,341	2,311	2,838	3,695	2,522
1983	3,246	3,719	2,399	2,856	4,000	2,545
1984	3,153	4,068	2,489	2,861	4,319	2,603
Average annual percentage change						
1978–81	[b]	17.0	6.5	2.9	16.7	5.9
1981–84	−2.2	10.6	3.1	−0.6	9.5	1.9
1978–84	−1.1	13.7	4.8	1.1	13.0	3.9

TABLE 16 (*Continued*)

Year or Period	AFDC Adults			AFDC Children		
	Recipients (Thousands)	Expenditures per Recipient		Recipients (Thousands)	Expenditures per Recipient	
		Nominal	Constant		Nominal	Constant
1978	4,370	597	597	10,047	322	322
1979	4,267	691	632	9,728	346	316
1980	4,585	711	585	9,762	384	316
1981	4,879	788	580	9,959	416	306
1982	5,023	821	548	9,931	416	278
1983	5,138	865	534	9,692	456	283
1984	5,155	869	504	10,040	477	279
Average annual percentage change						
1978–81	3.7	9.7	−1.0	−0.3	8.9	−1.7
1981–84	1.9	3.3	−4.6	0.3	4.8	−3.1
1978–84	2.8	6.5	−2.8	c	6.8	−2.4

a. Eligibility categories defined as in table 14, note b.
b. Less than 0.1.
c. Rate of decline of less than 0.1.

hospitals. This increase in the deductible is passed on to the Medicaid program for joint beneficiaries. Perhaps related to the increase in the Medicare deductible are the relatively high real rates of growth for hospital outpatient services (4.3 percent a year) and home health care (6.3 percent a year), both of which may be substituting to some extent for inpatient care. In summary, the growth in expenditures on the elderly has declined substantially since the pre-1981 period, but remains high compared with the growth for the AFDC populations.

The explanation of the continued high growth in expenditures on blind and disabled persons is similarly complex. Of particular importance were expenditures for persons in intermediate care facilities for the mentally retarded (ICF/MRs), which grew at rates that were much slower than the rates before 1981 (12.9 percent versus 35.8), but still, nonetheless, rapidly. Of much less importance overall, but still striking, was the increase in expenditures for home health services. These expenditures (which account for less than 3 percent of all spending on this category) rose by 28.8 percent a year between 1981 and 1984, reflecting a 9.2 percent increase in number of recipients and a 9.6 percent increase in real growth. A large share of the remainder of expenditures on the blind and disabled were for nursing home care and hospital inpatient services, both of which grew moderately (7.6 percent and 6.2 percent). Also important was the relatively rapid growth in hospital outpatient services and prescription drugs, the former reflecting both an increase in the number of recipients (3.7 percent) and an increase in real growth (3.1 percent)—the latter wholly attributable to increases in the underlying rate of inflation.

The pattern of spending for AFDC adults contrasted markedly with the patterns for elderly and blind and disabled people. Although the number of adult recipients increased continually throughout the seven-year period (by 3.7 percent before 1981 and 1.9 percent thereafter), nominal expenditures continued a pattern of relatively slow growth and real expenditures per recipient continued to decline. Real spending on hospital inpatient care—the largest category of Medicaid spending for this group—declined by 1.8 percent, in keeping with a national decline in use of hospital inpatient services. Real expenditures per recipient for physician services declined much more dramatically (by 6.8 percent a year), probably reflecting the declining willingness of physicians to care for the Medicaid population. Real expenditures per recipient for dental care also declined (by 5.9 percent), as did expenditures for prescription drugs (by 4.9 percent) and hospital outpatient care (by 3.3 percent). Thus, it appears that state efforts at curbing acute care costs have had a very real impact on the AFDC adult population: virtually all services of importance to this group have been cut substantially and, in

consequence, the overall rate of growth in expenditures for this group has remained low.

Were it not for the increase in numbers of recipients, the AFDC adults would have had the lowest growth rate in expenditures of all Medicaid recipient groups. Instead, that dubious distinction belongs to the AFDC children. Nominal expenditures for this group grew by 8.6 percent a year before 1981 and by 5.0 percent afterward, while the number of recipients was virtually the same in 1984 as in 1978. As with AFDC adults, children also suffered declines in real services: real spending for physician care declined by 5.1 percent; for dental care, by 9.0 percent; and for prescription drugs, by 4.4 percent. Again, as with AFDC adults, children bore the brunt of state efforts to control Medicaid acute care services.

Summary

The principal findings of this chapter can be summarized as follows.

There is a greater than fourfold difference among states in the likelihood that a given person will receive Medicaid. Interstate variations are even greater for adults and children. There is no apparent relationship between the proportion of a state's poverty population and the extent of the state's Medicaid coverage. Rather, variations in coverage reflect differences in state decisions on income standards and coverage of optional eligibility categories.

Since 1981 the numbers of adults between the ages of twenty-one and sixty-five and children enrolled in Medicaid has increased, but the number of adults and children in poverty has increased even faster. As a result, the ratio of Medicaid recipients to the poor population fell by 18.2 percent for adults and 13.7 percent for children.

Medicaid coverage of the poverty population is at a relatively low level. Approximately half of the poor children and one-third of the elderly and other adult populations in poverty were covered by Medicaid.

Spending on AFDC adults and children fell in real terms despite an increase in numbers of recipients. Spending fell because of sharp declines in spending for acute care services for which these beneficiary groups are disproportionate users. Expenditures on services for the elderly and disabled grew slightly in real terms despite the decline in recipients. Expenditures increased because these beneficiary groups were more likely to be using services that are increasing in cost, such as hospital outpatient care, nursing homes, ICF/MRs, and home health services.

CHAPTER 4

ACUTE CARE

Although the division between the acute and long-term care components of the Medicaid program is not formally recognized in any of the program's administrative or financing arrangements, there are a number of reasons for examining the two components separately. First, the two components primarily serve different constituencies. Although all recipients of Medicaid receive some acute care services (if only in the form of a physician's making a diagnosis), people in the Aid to Families with Dependent Children (AFDC) program categories make far greater use of most of these services than do the elderly and the blind and disabled, who in turn are by far the heaviest users of long-term care. Also, as we shall document, the two components exhibit very different patterns of expenditure growth. Furthermore, in the vast scheme of the nation's health care delivery system, Medicaid is only a minor purchaser of acute care services but is a major purchaser—*the* major one—for long-term care. Consequently, Medicaid's impact on, and prospects for influencing, long-term care are much greater than the impact on acute care. For all these reasons, analysts concerned with possible reforms of the Medicaid program have frequently focused on the administrative or financial division of acute and long-term care. This is a subject to which we return in the concluding chapter, but here we want to focus on the current picture of acute care in the Medicaid program.

Under current policies, state Medicaid programs are required to provide the Medicaid-eligible population with basic acute care services, including hospital inpatient care, physician services, laboratory and X-ray, and hospital outpatient care. The states also have a wide array of options for covering prescription drugs, dental services, podiatrists, chiropractors, psychologists, optometrists, eyeglasses, and so on. As is apparent from table 17, which provides a statistical picture of expenditures in 1984, hospital inpatient care

TABLE 17

TOTAL U.S. MEDICAID EXPENDITURES FOR ACUTE CARE SERVICES, 1984[a]

Type of Service	*Total Expenditures (Millions of Dollars)*	*Percentage of Total Acute Care*	*Number of Recipients (Thousands)*	*Expenditures per Recipient*	*Percentage of Expenditures on Various Categories of Recipients*[b]			
					Elderly	*Blind and Disabled*	*Children*	*Adults*
Hospital inpatient care	8,985.7	51.5	3,428.7	2,620.70	16.1	34.5	24.1	25.2
Physician services	2,460.4	14.1	14,216.9	173.06	11.5	24.4	30.8	33.2
Hospital outpatient care	2,231.3	12.8	10,509.1	212.32	6.6	32.9	33.3	27.1
Prescription drugs	2,010.5	11.5	13,968.8	143.93	38.6	34.6	11.3	15.5
Dental care	474.3	2.7	4,967.7	95.48	6.3	11.9	49.9	31.9
Other care	1,280.4	7.4	9,585.2	133.58	23.5	33.6	22.6	20.3
Total acute care	17,442.6	100.0	20,067.7[c]	869.19	17.1	32.2	25.3	25.3

a. Totals may not add due to rounding.

b. Eligibility categories defined as in table 14, note b.

c. The number of total acute care recipients is less than the sum of recipients for each service because individuals who use more than one type of service are only counted once in the total.

accounts for the predominant share of all acute care spending. The largest users of acute care services in general were the blind and disabled, but the distribution of expenditures among eligibility groups varies considerably among services. A major reason for these patterns is that Medicare covers most acute care services for the elderly and some disabled.

Table 18, which provides information on changes in expenditures, recipients, and expenditures per recipient from 1978 to 1984, documents the extent to which the growth of acute care spending has been arrested in the post-OBRA years. Whereas the size of the recipient population changed only negligibly in the pre- and post-OBRA periods, real expenditures per recipient grew substantially before 1981 but fell after that year. The truly precipitous drop occurred in 1982, but real growth rates in 1983 and 1984 did not return to the pre-OBRA levels.

In this chapter, we review the changes in expenditures, recipients, prices, and services for each of six service categories: hospital inpatient care, physician services, hospital outpatient care, prescription drugs, dental care, and "other" (such as miscellaneous optional services). The evidence shows that reductions in spending were spread broadly among most categories. Although the reduction in real spending for hospital inpatient care turned out to be particularly important overall (because that service accounts for more than

TABLE 18

TOTAL U.S. MEDICAID EXPENDITURES FOR ACUTE CARE SERVICES, 1978–84

Year or Period	*Total Expenditures (Millions of Dollars)*	*Number of Recipients (Thousands)*	*Expenditures per Recipient (Dollars)*		*Medicaid Price Index*[a]
			Nominal	*Constant*	
1978	9,512.7	20,455.4	465.05	465.05	1.00
1979	10,604.8	20,072.2	528.33	483.77	1.09
1980	12,286.8	20,205.2	608.10	500.72	1.21
1981	14,585.2	20,519.5	710.80	524.80	1.35
1982	15,114.4	20,149.8	750.10	500.47	1.50
1983	16,643.6	19,936.0	834.85	514.39	1.62
1984	17,442.6	20,067.7	869.19	502.98	1.73
Annual compound rate of growth					
1978–81	15.3	0.1	15.2	4.1	10.6
1981–84	6.1	−0.7	6.9	−1.4	8.4
1981–82	3.6	−1.8	5.5	−4.6	10.6
1982–84	7.4	−0.2	7.7	0.3	7.4

a. For a description of this index see appendix A.

half of all acute care spending), the declines in real spending growth rates were greatest for physician services, dental care, and "other" services.

Hospital Inpatient Care

Hospital inpatient care is the most important single service covered by the Medicaid program, accounting for more than 25 percent of all Medicaid expenditures in 1984, but in the pre-OBRA years it had not been an important target for Medicaid cost-containment efforts. The primary reason for the lack of attention to inpatient costs lay in the choice of method by which states reimbursed hospitals. Most states followed the practice of "reasonable cost reimbursement," according to which costs were retrospectively determined following Medicare-based accounting principles for allocating costs to different revenue centers, and hospitals were then reimbursed the full allowable costs for serving Medicaid patients. This arrangement, also used by the Medicare program, was widely criticized for its inflationary effects. Although states had the option—with approval from the Department of Health and Human Services—of using something called "the alternative method," which involved payment of rates rather than actual costs, few states took the option. Before 1982, only 10 Medicaid programs (but these were among the largest) had approved alternative systems: California, Colorado, Idaho, Maryland, Massachusetts, Michigan, New Jersey, New York, Rhode Island, and Wisconsin (Bovbjerg and Holahan 1982).

Other states were reluctant to get into rate setting for a number of different reasons. First, many regarded rate setting as just another form of regulation, which would lead to burdensome red tape, collusion between regulators and regulated, and so on, and thus fail to control rising hospital costs. Also, developing an alternative system that met pre-1981 federal requirements was difficult, as was implementing the system. Several hospital associations successfully brought lawsuits against states with alternative systems, and the frequency of lawsuits increased the costs of the systems and muted their benefits. Furthermore, even if the systems did effectively control costs, several states were concerned that rate setting would also reduce access. Because Medicaid provides a small share of a typical hospital's revenues, the system seemed less likely to alter a hospital's behavior with regard to costs than to alter the hospital's willingness to serve Medicaid patients. Finally, several states feared that rate setting might have adverse effects on the fiscal health of hospitals. Many of the hospitals serving Medicaid patients also serve other indigent portions of the population. Already under severe fiscal pressure, these hospitals are unable to recoup lost revenues by increasing charges to privately insured patients. Thus, states had incentives to be as generous as

possible through Medicaid, so as to obtain higher federal matching payments and relieve the fiscal pressure on financially distressed hospitals.

All this seems to have changed with the 1981 Omnibus Budget Reconciliation Act. This act eliminated altogether the federal requirement for reasonable cost reimbursement and permitted states to pay only the "reasonable and adequate rates" needed to meet the costs of "efficiently and economically operated facilities." States can now set ceilings on rates of payment that are independent of what a particular hospital spends or of increases in the costs of goods and services used by the hospitals. Along with the legislative changes, HCFA has eased its approval process considerably, so that states can more easily implement alternative arrangements. In consequence—and also in response to mounting fiscal pressure—many states have implemented new arrangements or tightened existing ones. As shown in table 19, forty states employed Medicare retrospective cost-based payment systems in 1980 (Laudicina 1985), while the remainder had some form of prospective system, negotiation or contracting systems, or a retrospective system with prospective limits on the rate of increase in ceilings. By 1983, the number of states that had retrospective cost-based systems had dropped to twenty-five. The number of states that had prospective systems with rate-of-increase controls (with or without peer group ceilings) had increased from five to fifteen. By 1985 only fourteen states had retrospective cost-based systems, whereas twenty-three

TABLE 19

SUMMARY OF STATE MEDICAID HOSPITAL REIMBURSEMENT SYSTEMS, 1980–85

Characteristics of Systems	*Numbers of Systems*[a]		
	1980	*1983*	*1985*
Medicare retrospective cost-based principles	40	25	14
Retrospective rate of increase controls	1	4	4
Prospective systems			
Budget review	5	3	2
Rate of increase controls without peer-group ceilings	2	7	13
Rate of increase controls with peer-group ceilings	3	8	10
Case mix	2	2	7
Negotiation or contracting systems	1	3	5

SOURCE: Susan S. Laudicina, "A Comparative Survey of Medicaid Hospital Reimbursement Systems for Inpatient Services, State-by-State, 1980–1985," Intergovernmental Health Policy Project (Washington, D.C.: George Washington University, December 1985).

a. The sum of numbers across the years adds to more than the number of states because some states have more than one system.

states had prospective systems with rate-of-increase controls or peer group ceilings or both. Also, seven states had introduced prospective case-mix systems such as Medicare's diagnostic related groups (DRG) arrangement. (The DRG system pays hospitals at set rates per admission according to diagnosis or type of case.)

The move toward prospective payment is clear. The systems of the states, however, vary in sophistication. Thirteen states employ prospective systems that are essentially controls on rates of increase: that is, a hospital's base-year costs are projected forward by some trend factor to establish future-year rates. These systems thus accept any inefficiency in the base-year level of costs and attempt only to control rates of increase. Ten states now group hospitals into peer groups, establish ceilings on the maximum rates they will pay, and pay the hospital its own costs projected forward as just described or the ceiling projected forward to the rate year, whichever is less. Finally, some states have linked their Medicaid reimbursement system to an all-payer or multiple-payer rate setting system, under which Medicaid pays hospitals through the same methodology and, in some instances, at the same rate as other payers. New York, Massachusetts, Maryland, and New Jersey already have such systems, and several other states (Connecticut, Maine, Washington, and West Virginia) are developing them.

Evidence is mounting that these all-payer systems are effective in controlling costs. A recent study by Zuckerman (1985), for example, demonstrated that states with all-payer systems experienced lower rates of increase in hospital costs than did states without such systems. He also demonstrated that by 1983 the levels of hospital costs were lower in all-payer states than in other states after controlling for wage rates, case mix, and teaching status. Zuckerman (1986) has also shown that Medicaid programs benefit from the cost-constraining effects of all-payer systems and that Medicaid payment rates are also reduced in Medicaid-only rate-setting states.

Ten states—Michigan, Minnesota, New Jersey, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, Utah, Washington—adopted prospective payment per discharge arrangements similar in design to the Medicare DRG system. The New Jersey system served as the model for the present Medicare prospective payment system, but differs from Medicare in being a blend of hospital-specific rates and DRG rates. New Jersey permits a much greater degree of interhospital variation than will ultimately be permitted in Medicare; the state also has a much more generous policy toward "outliers," that is, severe cases. Spurred by the apparent success of the Medicare DRG system, Colorado, Connecticut, Montana, Nevada, and Texas all have DRG proposals under serious consideration (Laudicina 1985).

California and Illinois are two states that have adopted particularly stringent Medicaid-only systems of reimbursement. In 1983, California established its "selected provider contracting program," under which the state negotiated all-inclusive per diem rates individually with eligible hospitals; once the rate was determined, the hospitals had to absorb costs that exceed the negotiated level. MediCal (California's name for Medicaid) patients were required to go to a contracting hospital; contracting facilities were required to treat MediCal patients coming to them. Contracting applied to more than half of California's hospitals and more than three-quarters of its hospitalizations. Hospitals outside the contracting system were subject to the old state system of peer group ceilings on a per discharge basis. Rates for the first year of the California contracting system were estimated to be 16 percent below what they would have been under the previous system, with the largest rate reductions coming from state teaching hospitals. Expenditures were reported to total $140 million less than the amount that would otherwise have been spent. Second-year spending was expected to be even greater. The cost-control effectiveness of the contracting system was undoubtedly augmented by California's very aggressive utilization review program, which requires prior authorization for each admission and concurrent review every three days thereafter (Laudicina 1985).

California focused only on controlling per diem rates, but Illinois has mounted a major effort to control overall Medicaid expenditures per hospital as well. The state first estimated the utilization level for each hospital and projected forward to 1982 the fiscal 1979 costs a day for each hospital. The state then projected its own spending for total hospital services for the fiscal 1982 period by multiplying each hospital's projected unit cost figure by estimated utilization and adding the costs across hospitals. Comparing this total with available state funds and finding that the former exceeded the latter, the state cut rates for all hospitals by 14.3 percent. In a major departure from past practices and from Medicare reimbursement arrangements, the state thus tailored its payments to its own judgment of its ability to pay. Hospitals that reduced utilization would have rate increases to make up the 14.3 percent reduction.

In 1983, Illinois's system was made still more stringent. Hospital rates were increased by 10 percent per day, but the state set a cutoff on the number of days for which it would reimburse at the eightieth percentile for length of stay on a diagnosis-specific basis.

In addition to changing their reimbursement systems, states have become increasingly aggressive in using other controls on hospital utilization. Some states flatly limit the number of hospital days they will cover per year. Others

employ a more sophisticated procedure, using hospital length-of-stay statistics developed by the professional activity system of the Commission on Professional Hospital Activity to limit lengths of stay on a diagnosis-specific basis to some percentile, such as the fifthieth or seventy-fifth, of the distribution of stays. In addition, numerous states have imposed more special controls, such as bans on nonemergency weekend hospital admissions, limits on preoperative hospital stays, and exclusion of certain inpatient hospital procedures that can be performed on an outpatient basis. Also, many states have developed a variety of review processes to limit the coverage of "unnecessary" services.

These various efforts at cost control appear to have been effective, although it is hard to differentiate cause from effect precisely. Data on spending for hospital inpatient care demonstrate a substantial drop since 1981 (table 20); whereas increases in spending had averaged 14.7 percent a year before OBRA, they averaged only 6.7 percent afterward. Part of the decline is clearly attributable to an accelerating drop in number of recipients post-OBRA. Some of the decline is also clearly attributable to a drop in the underlying rate of hospital input price inflation, which fell from an 11.1 percent annual growth rate between 1978 and 1981 to 8.0 percent thereafter. Most important, however, was a decline in the real growth rate of expenditures per recipient from 3.8 percent to 0.9 percent.

This decline was particularly sharp in 1982, probably reflecting the widespread use of utilization controls and the beginning of rate-control pro-

TABLE 20

TOTAL U.S. MEDICAID EXPENDITURES FOR INPATIENT HOSPITAL SERVICES, 1978–84

Year or Period	*Total Expenditures (Millions of Dollars)*	*Number of Recipients (Thousands)*	*Expenditures per Recipient (Dollars)*		*Medicaid Price Index*
			Nominal	*Constant*	
1978	4,895.6	3,696.8	1,324.30	1,324.30	1.00
1979	5,558.9	3,535.7	1,572.22	1,435.56	1.10
1980	6,381.1	3,622.2	1,761.67	1,441.86	1.22
1981	7,388.4	3,646.9	2,025.92	1,479.10	1.37
1982	7,728.2	3,474.2	2,224.48	1,463.18	1.52
1983	8,732.6	3,612.3	2,417.46	1,480.29	1.63
1984	8,985.7	3,428.7	2,620.70	1,519.60	1.72
Annual compound rate of growth					
1978–81	14.7	−0.5	15.2	3.8	11.1
1981–84	6.7	−2.0	9.0	0.9	8.0
1981–82	4.6	−4.7	9.8	−1.1	11.0
1982–84	7.8	−0.7	8.5	1.9	6.5

grams in several states. The 1.9 percent real growth rate between 1982 and 1984 was about half the pre-OBRA rate but above the general rate of hospital input price inflation. The latter effect was probably attributable to the widespread success in controlling hospital costs resulting from Medicare and private sector initiatives as well as Medicaid. The reductions in hospital spending due to the Medicare prospective payment system have helped Medicaid programs by reducing growth in hospital costs per admission but, ironically, the reductions have adversely affected states by increasing costs per day. This situation occurs because Medicaid programs pay the deductible for the first day in the hospital under Medicare, which has risen sharply since 1983. For other eligibility groups, real expenditures per recipient are either constant or declining, providing further support for the impact of Medicaid hospital payment policies.

Because of the decline in the hospital input price inflation and in real spending per recipient, the growth of expenditures per recipient fell from 15.2 percent (1978–81) to 9.0 percent (1981–84). Both influences seem likely to continue. Medicaid rate setting programs are now widespread, suggesting that reductions in Medicaid spending are likely to continue. Medicare's prospective payment system also seems to be very effective in reducing growth in hospital costs, and private sector experience seems to be even better. Thus, it seems likely that Medicaid expenditures per recipient of inpatient care will continue to grow more slowly than in the pre-OBRA years.

Physician Services

Physician services, which in 1984 accounted for 5.8 percent of all Medicaid expenditures and 13.5 percent of acute care services, have always been more susceptible to state cost controls than virtually any other Medicaid service. The federal government has never imposed a specific method of payment for physicians, requiring only that reimbursement rates be high enough to ensure reasonable access to care but that they not exceed Medicare levels. In the early days of the program, states typically paid Medicare fees or at least used Medicare's "usual, customary, and reasonable" (UCR) charge principles. They did so in the interest of administrative convenience and in line with the objective of achieving high participation rates by physicians. But as Medicare itself began to limit its reimbursements, many states became concerned about overall spending and found physicians an especially attractive target. In the early and mid-1970s a number of states, including most of the large industrial states in the East and Midwest, changed to fee schedules or applied lower ceilings within the UCR framework (Holahan 1984).

A 1980 survey showed that most large states paid physicians considerably less than did Medicare, which in turn paid less than private insurers (Holahan 1984). Table 21 shows the ratio of Medicaid to Medicare fees for specialists in 1979. The ratios indicate that states using Medicare UCR principles paid rates relatively close to those used by Medicare, whereas fee-schedule states paid much lower rates. Note that the largest Medicaid programs are all in the bottom half of the table. New York, for example, paid specialists in 1979 at rates that were 24 percent of Medicare levels. Whether low fees actually result in lower Medicaid costs is debatable because the low fees probably lead to low physician participation, which in turn probably leads to reliance by the poor on hospital outpatient departments and emergency rooms, often in more expensive teaching hospitals.

In the 1980s, states have apparently again found physicians an easy target: some states have reduced fees and others have imposed direct limits on the number of visits they would reimburse. The Health Care Financing Administration (HCFA) indicates that about thirty-three states, accounting for 71.6 percent of Medicaid physician expenditures, now employ some form of a fee schedule (HCFA 1984b). The remaining seventeen states, accounting for 28.4 percent of expenditures, continue to use a variant of the Medicare UCR system, but because some of these states do not regularly update prevailing charge screens their systems have become tighter over time.

The post-1980 increase in restrictiveness of Medicaid physician fees is evident from data provided in table 21. The ratios of Medicaid fees to Medicare fees fell between 1979 and 1984 in all but three states, indicating that physicians are likely to find Medicaid patients increasingly less attractive.

The states have not, however, been uniformly and indiscriminately restrictive in changing their physician reimbursement policies. Some, in fact, have been quite innovative. Kansas, for example, increased reimbursement amounts for selected physician services (office visits, in-office medical supplies, diagnostic and surgical procedures, nursing home visits, emergency room visits, and obstetrical services) to encourage physicians to provide care outside the hospital. The state also reimbursed physicians in hospitals for normal obstetrical deliveries at a higher rate if the mother was in the hospital for forty-eight hours or less. Similarly, in an effort to reduce reliance on inpatient care, Missouri increased physician office fees and fees for deliveries performed in the office. The state also added coverage of previously restricted surgical procedures in an office or clinic setting, to encourage performance of these procedures outside the hospital setting. With like intent, Ohio initiated an "outpatient and office surgery incentive program," under which outpatient reimbursement rates were increased by 20 percent and office visit payments increased between $25 and $50 per selected list of surgical procedures. These

TABLE 21

RATIOS OF MEDICAID TO MEDICARE FEE LEVELS FOR SPECIALISTS, 1979 AND 1984

State	*Type of Reimbursement System*[a]	*Fee Ratio*	
		1979	*1984*
Nevada	RVS	1.13	0.87
Delaware	CPR	1.06	0.83
Minnesota	CPR	1.06	0.87
Louisiana	CPR	1.02	0.56
Indiana	CPR	1.00	0.71
Iowa	CPR	1.00	0.86
Nebraska	CPR	1.00	0.88
North Carolina	CPR	1.00	0.72
Oklahoma	CPR	1.00	0.94
Texas	CPR	1.00	0.72
Utah	CPR	1.00	0.99
Wisconsin	CPR	1.00	0.78
Wyoming	CPR	1.00	1.02
Kentucky	CPR	0.99	0.90
North Dakota	CPR	0.98	0.72
South Carolina	CPR	0.95	0.64
New Mexico	CPR	0.94	0.64
Hawaii	CPR	0.93	0.66
Oregon	FS	0.90	0.71
South Dakota	CPR	0.90	0.75
Tennessee	CPR	0.90	0.80
Idaho	FS	0.89	0.57
Georgia	CPR	0.88	0.72
Alabama	CPR	0.83	0.86
Washington	RVS	0.80	0.57
Michigan	FS	0.78	0.49
Mississippi	FS	0.77	0.67
Montana	FS	0.76	0.70
Ohio	CPR	0.74	0.51
Vermont	FS	0.72	0.52
Colorado	RVS	0.71	0.86
Kansas	CPR	0.70	0.50
New Hampshire	FS	0.69	0.47
West Virginia	FS	0.68	0.47
Maine	FS	0.65	0.44

TABLE 21 (*Continued*)

State	*Type of Reimbursement System*[a]	*Fee Ratio*	
		1979	*1984*
California	RVS	0.62	0.48
Massachusetts	FS	0.62	0.48
Virginia	FS	0.62	0.45
Illinois	FS	0.61	0.42
Rhode Island	FS	0.59	0.45
Connecticut	RVS	0.54	0.45
Missouri	FS	0.54	0.40
Florida	RVS	0.52	0.36
Maryland	FS	0.51	0.39
New Jersey	FS	0.41	0.29
Pennsylvania	FS	0.37	0.22
New York	RVS	0.33	0.23

SOURCE: Joel Cohen, "Medicaid Policy and the Substitution of Outpatient for Physician Care," Working Paper 3339-10, Washington, D.C.: The Urban Institute, forthcoming.

a. CPR is Customary, Prevailing, and Reasonable (Medicare terminology; Medicaid uses similar terminology, UCR for Usual, Customary, and Reasonable); FS is Fee Schedule; and RVS is Relative Value Schedule.

and other such efforts indicate that states are not unaware of the incentives facing physicians, although on the whole they remain biased toward seeking Medicaid economies from this segment of service provision.

Yet another restraint on this bias was removed by a provision in the 1981 OBRA legislation that permitted HCFA to grant waivers on the Medicaid statute's requirements governing the freedom of choice of care-provider. The new provisions permit states to establish case management systems for primary care, permit providers to share with recipients the savings from programs that prove cost-effective in delivering medical care, allow localities to establish arrangements under which recipients select among competing health care plans, and restrict recipients to receiving services from low-cost providers. The legislation also eased the requirements for states to engage in volume purchasing for laboratory and X-ray services and medical supplies.

Of these various provisions, the one pertaining to primary care case management is probably the most significant. Primary care case management has come to mean a number of things, but the common denominator is the assumption that having one physician or one group of physicians act as "managers" of a case will enable patient beneficiaries to obtain a higher

quality of services and at the same time reduce the cost of acute care services (by reducing "doctor shopping" and reliance on expensive teaching institutions for routine outpatient care). To date, little data are available to support this assumption because few primary care case management systems are operational (NGA, 1985). (As of May 30, 1986, twenty-one states had submitted forty-two applications to establish primary care case management systems; HCFA had approved twenty-nine of these proposals, of which twenty-two became operational and nineteen are still in operation.)

What evidence there is suggests that most states will limit the primary care case management systems to specific geographic areas and populations of recipients. Only Colorado, Kansas, and Kentucky operate programs that are essentially statewide. For several reasons, states have limited enrollment in these programs to certain groups of beneficiaries. Typically, the systems serve only the Medicaid-eligible AFDC population; a few extend coverage to the elderly, blind, and disabled. Typically, also, the elderly population also eligible for Medicare is excluded, as are people in long-term care institutions and the medically needy. As of mid-1986, the nineteen case management programs currently operational (which include some that are capitated, that is, paid on a per person basis rather than per service) are serving between 600,000 and 700,000 Medicaid beneficiaries—about 4 percent of the total monthly enrollees—and most of the enrollees are in five large programs (Colorado, Kentucky, Michigan, Pennsylvania, West Virginia).

Nine primary care case management programs with about 400,000 enrollees have not placed physicians or physician groups at risk. Rather, other methods such as offering small case management fees or assuring physicians access to Medicaid beneficiaries are used as inducements for providers to participate. The other programs place physicians at some risk, usually capitating them for primary care and referral services and sharing with them any savings resulting from reduced inpatient utilization. Interest in capitated arrangements is growing. As of March 1986, almost 850,000 Medicaid recipients are enrolled in health maintenance organizations (HMOs) and similar prepaid plans. (This figure includes some enrollees counted under waivered primary care case management programs.)

The number of HMO enrollees has tripled since June 1981. About 30 percent of these enrollees reside in areas in which the state requires Medicaid recipients to select an HMO, and another 15 percent or so were required to designate some primary care providers, although it need not have been an HMO. Strictly voluntary enrollment in HMOs is also growing in states that have sought to encourage it, but growth is slower for several reasons. Standard Medicaid benefit packages are quite generous compared with HMO packages—and Medicaid recipients are not required to pay the premiums that

HMO members are. Also, HMOs require a kind of stable commitment hard to obtain from the Medicaid population, with its typically high turnover. Finally, capitation arrangements may be unattractive to physicians unless capitation rates are high, but rates that are high enough to generate significant physician participation are likely to result in higher levels of expenditures.

In aggregate, all the efforts that have been discussed appear to have had a substantial impact on Medicaid expenditures for physician services. As indicated in table 22, growth in these expenditures dropped off precipitously after 1981, increasing by only 2.0 percent a year (1981–84) after rising 11.0 percent a year between 1978 and 1981. Since the number of recipients remained virtually unchanged over the entire period, and the physician fee component of the consumer price index dropped only slightly, the spending slowdown is almost entirely attributable to a reduction in the rate of growth of expenditures per recipient. In constant dollars, expenditures per recipient dropped from a 0.1 percent increase each year prior to 1981 to a 5.4 percent annual decline after 1981.

It is hard to know just what to make of this sharp reduction. On the one hand, it probably testifies to the efficacy of Medicaid fee restraints, which have held Medicaid physician fees below the level of general fee inflation. On the other hand, the reduction in expenditure per recipient growth in real terms undoubtedly also reflects fewer services per recipient. This situation, in turn, could reflect the unwillingness of physicians to provide services in

TABLE 22

TOTAL U.S. MEDICAID EXPENDITURES FOR PHYSICIAN SERVICES, 1978–84

Year or Period	*Total Expenditures (Millions of Dollars)*	*Number of Recipients (Thousands)*	*Expenditures per Recipient (Dollars)*		*Medicaid Price Index*
			Nominal	*Constant*	
1978	1,697.6	14,344.8	118.34	118.34	1.00
1979	1,785.3	13,750.7	129.84	119.08	1.09
1980	2,018.2	13,764.4	146.63	120.34	1.22
1981	2,321.4	14,403.0	161.17	118.80	1.36
1982	2,274.4	13,893.5	163.70	110.60	1.48
1983	2,380.2	14,056.0	169.34	105.72	1.60
1984	2,460.4	14,216.9	173.06	100.52	1.72
Annual compound rate of growth					
1978–81	11.0	0.1	10.9	0.1	10.7
1981–84	2.0	−0.4	2.4	−5.4	8.3
1981–82	−2.0	−3.5	1.6	−6.9	9.1
1982–84	4.0	1.2	2.8	−4.7	7.9

response to the continued deterioration in fees. The reduction in services per recipient but not number of recipients, in any event, is consistent with recent research findings that physician participation rates (willingness to treat at least some patients) have not declined as much as the amount of service provided (Held and Holahan 1985).

Hospital Outpatient Services

Hospital outpatient department and clinic services have grown rapidly since the mid-1970s and now account for almost 12.2 percent of Medicaid's acute care expenditures (and 5.3 percent of total spending). Reasons for the rapid growth are not clear. It may reflect increased reliance on hospital outpatient departments and emergency rooms in response to low physician participation rates. A more optimistic interpretation is that the rapid growth may reflect increased use of outpatient departments to provide services previously done on an inpatient basis. This latter trend has been going on independent of Medicaid and is likely to continue with the emergence of case-related reimbursement systems that encourage hospitals to reduce lengths of stay.

Little is known about state policies toward outpatient departments, and very little systematic information on utilization control and reimbursement policy has been collected. We can observe, though, that historically states have not been nearly so concerned with controlling the cost of hospital outpatient departments as with controlling the cost of physician services. Reimbursement policy now, however, seems to be changing. In the late 1970s and early 1980s, most hospitals were paid on a Medicare model of reasonable cost basis: that is, hospitals' allowable costs were allocated to outpatient departments, and Medicaid essentially paid its fair share. Recognition that this method of payment, like retrospective cost-based reimbursement for inpatient care, does little to encourage efficiency in hospital operations has led many states to adopt fee schedules or some other alternative system. By 1984, twenty-four states, which account for almost 71 percent of outpatient expenditures, reimbursed on other than Medicare principles. It is unfortunate, however, that little detail is available now on these alternative systems.

As already noted and documented in table 23, expenditures for hospital outpatient care have grown rapidly—much faster than those for physician services, even in the pre-OBRA period (17.5 percent versus 11.1 percent a year). A small share of the growth was due to an increase in number of recipients (1 percent a year), but the majority was in expenditures per recipient, which increased 13.3 percent a year before 1981. In part this reflected a high growth rate in hospital input costs, but it also reflected a significant—2 percent—real rate of growth.

TABLE 23

TOTAL U.S. MEDICAID EXPENDITURES FOR OUTPATIENT SERVICES, 1978–84

Year or Period	Total Expenditures (Millions of Dollars)	Number of Recipients (Thousands)	Expenditures per Recipient (Dollars)		Medicaid Price Index
			Nominal	Constant	
1978	1,015.0	9,244.3	109.80	109.80	1.00
1979	1,106.9	9,190.2	120.44	109.97	1.10
1980	1,360.2	9,845.9	138.15	113.07	1.22
1981	1,646.4	10,315.6	159.61	116.53	1.37
1982	1,773.4	10,104.2	175.51	115.45	1.52
1983	1,959.1	10,215.8	191.77	117.43	1.63
1984	2,231.3	10,509.1	212.32	123.11	1.72
Annual compound rate of growth					
1978–81	17.5	3.7	13.3	2.0	11.1
1981–84	10.7	0.6	10.0	1.9	8.0
1981–82	7.7	−2.1	10.0	−0.9	11.0
1982–84	12.2	2.0	10.0	3.3	6.5

After OBRA, expenditures increased by 10.7 percent a year. The decline in the rate of increase is attributable to a reduction in underlying hospital input cost inflation and a lower real growth rate. Hospital costs increased an average of 11 percent a year before 1981 versus 8 percent afterward. Real service increases were basically constant, averaging 2 percent before 1981 and 1.9 percent afterward, but this average exaggerates the magnitude of change between 1981 and 1984, because it encompasses a very sharp decline in 1982, after which services resumed growing at a real rate closer to the pre-OBRA experience. After 1981, more and more states moved away from cost-based reimbursement, and so the increase in the real rate of growth probably does not reflect payment increases in excess of general hospital cost increases. It is more likely that it reflects an increasing number of services per recipient for either of the reasons mentioned earlier: recipients are turning to outpatient departments because they cannot obtain the service from an independent physician or they are receiving services from outpatient departments that would previously have required hospitalization. In addition, table 23 indicates that the number of recipients increased by 2 percent a year between 1982 and 1984, again supporting the argument of a movement away from private physicians. If this is the case, it represents a dubious economy for the Medicaid program, because the cost of outpatient services is often high relative to the cost of physician services. Outpatient services also appear more concentrated,

with almost 60 percent of all national expenditures occurring in California, Massachusetts, Michigan, New Jersey, New York, Ohio, and Pennsylvania.

Prescription Drugs

Of the acute care services that states may cover in their Medicaid programs, prescription drugs are fiscally the most important, accounting for 11.5 percent of all acute care expenditures. All but two states cover prescription drugs and together they spend approximately $2 billion on the service. About $777 million—38.6 percent—of this sum is spent on the elderly. (Medicare, which is a major insurer of medical care for the elderly, does not cover prescription drugs.) Another 35 percent goes for prescriptions used by the blind and disabled and the remainder of the AFDC categories.

Throughout the 1980s, the majority of states as reported by the various publications of the National Governors' Association (NGA) were proposing or imposing limits on their drug coverage; for example, tightening the drug formulary to restrict the number and kinds of drugs covered, adopting lock-in arrangements for recipients who overuse prescription drugs, eliminating over-the-counter drugs, requiring use of generic drugs, limiting the number of drugs per month, and imposing copayments on prescriptions. Some states have experimented simultaneously with several different sorts of limits. In 1982 and 1983, Michigan, for example, eliminated several "less effective" drugs from coverage; increased by thirteen the number of pharmaceutical items subject to maximum allowable cost limitations; eliminated potassium supplements from coverage; eliminated clinically equivalent drugs from coverage; eliminated pharmacy coverage of laxative, antacid, antivertigo, vitamin, hematinic, and cough and cold drugs; and eliminated Ativin and Valium from coverage (NGA 1983). Also, copayments on prescriptions ranging from about $0.50 to $3.00 have become increasingly common. Nineteen states reportedly had copayment policies in 1984, while eleven states reported limits on the number of prescriptions per month and twenty-eight states limited the number of refills per month.

Perhaps at least partly in response to such policies, expenditures on prescription drugs declined, as shown in table 24, from annual rates of increase of 14.5 percent before 1981 to 8.2 percent afterward. The pre-OBRA increases were due to underlying inflation and real growth of 5.1 percent in services, whereas the post-OBRA decline reflects both a small decline in the number of recipients and a 2 percent real drop in services.

Part of the post-OBRA experience reflects the sharp decline occurring in 1982, when recipients and real services declined precipitously. Between 1982 and 1984, recipients increased by 1.6 percent a year, services declined

TABLE 24

TOTAL U.S. MEDICAID EXPENDITURES FOR PRESCRIPTION DRUGS, 1978–84

Year or Period	*Total Expenditures (Millions of Dollars)*	*Number of Recipients (Thousands)*	*Expenditures per Recipient (Dollars)*		*Medicaid Price Index*
			Nominal	*Constant*	
1978	1,056.2	14,160.9	74.59	74.59	1.00
1979	1,171.0	13,372.5	87.56	81.10	1.08
1980	1,336.7	13,699.5	97.58	83.49	1.17
1981	1,585.9	14,248.2	111.31	86.47	1.29
1982	1,612.0	13,535.2	119.10	82.53	1.44
1983	1,781.3	13,723.7	129.79	80.12	1.62
1984	2,010.5	13,968.8	143.93	81.18	1.77
Annual compound rate of growth					
1978–81	14.5	0.2	14.3	5.1	8.8
1981–84	8.2	−0.7	8.9	−2.1	11.3
1981–82	1.6	−5.0	7.0	−4.6	12.1
1982–84	11.7	1.6	9.9	−0.8	10.8

by a modest 0.8 percent, and expenditures increased by 11.7 percent. The outlook for the future is less clear. The evidence suggests that prescription drug outlays will be determined by the number of Medicaid recipients and by the general inflation in drug prices.

Dental and Other Services

Of the remaining optional acute care services, dental care accounts for the largest single share of expenditures—$747 million—while all other services together (those provided by optometrists, chiropractors, podiatrists, family planners, and rehabilitation therapists) total $1.3 billion. Half of Medicaid dental expenditures are made on behalf of children, and another 32 percent are for AFDC adults. Expenditures on other optional services are spread more evenly across all eligibility groups, although obviously any particular service—such as family planning—may have a narrow clientele.

We have little specific information on state policies toward these services. Most states cover some, and some states cover all, but in general these optional services have been subject to many state-imposed limits and have been the target of aggressive cost-containing policies throughout the life of the Medicaid program. Controls include limits on the types of services covered, prior authorization of more expensive services including dental surgery and other

forms of care, use of copayments, and stringent limits on reimbursement rates.

One source of data, the reports of the Intergovernmental Health Policy Project (IHPP 1982–85), suggests that after a post-OBRA period of even greater stringency, the states may be embarking on an expansionary phase. IHPP reported that, by 1982, several states adopted copayments on eyeglasses, dental care, and other optional services and twenty-six states had eliminated certain optional services, limited the duration and scope of others, and restricted the types of people eligible for particular services.

In its April 1983 report, IHPP saw signs of a turnaround: although four states had reduced the amount, scope, and duration of services, five others were reported to have reinstated services previously curtailed, and several others were considering similar expansions. In its December 1983 report, IHPP reported that twenty-six states had increased and only twelve reduced the amount, duration, and scope of their optional services. Fifteen states added at least one new service and five reinstated services that had been eliminated in the previous two years. Subsequent reports tell similar stories. The IHPP data suggest a clear trend: states are selectively increasing their coverage of the smaller (in terms of expenditures) optional services that bore the brunt of the cutbacks in the 1981–82. The expansions seem to reflect a commitment on the part of the states to provide what they deem to be needed services when fiscal conditions permit.

But this conclusion is not altogether borne out by spending data. Consider, for example, expenditures for dental benefits (table 25). Before 1981, expenditures had risen by 13.1 percent a year, reflecting an increase of 5.6 percent a year in number of recipients and general inflation of 10.1 percent. Real services actually declined by 2.7 percent, reflecting restraints on fees or reductions in services. After 1981, expenditures declined by 5.5 percent in nominal terms, but the number of recipients fell by only 1.3 percent. The expenditure reduction is thus primarily attributable to a decline of 10.5 percent in real services, again suggesting the widespread use of fee controls and service limitations. Expenditures showed a particularly large drop from 1981 to 1982 as a result of both a 6 percent decline in number of recipients and a 5.7 percent decline in expenditures per recipient. Between 1982 and 1984, number of recipients grew by 1.0 percent but expenditures per recipient continued to decline, indicating continued spending restraint on the part of the states throughout the period. The spending evidence indeed, far from implying expansion, suggests a major effort to reduce dental expenditures and shift to other priorities. We can only surmise that whatever efforts at expansion in these areas may be in progress have yet to translate into increased utilization.

TABLE 25

TOTAL U.S. MEDICAID EXPENDITURE FOR DENTAL SERVICES, 1978–84

Year or Period	Total Expenditures (Millions of Dollars)	Number of Recipients (Thousands)	Expenditures per Recipient (Dollars)		Medicaid Price Index
			Nominal	Constant	
1978	388.6	4,391.6	88.50	88.50	1.00
1979	426.0	4,342.6	98.10	90.11	1.09
1980	467.6	4,651.8	100.53	83.12	1.21
1981	561.5	5,172.9	108.55	81.43	1.33
1982	498.1	4,867.8	102.33	72.12	1.42
1983	470.9	4,939.2	95.34	63.60	1.50
1984	474.3	4,967.7	95.48	58.33	1.64
Annual compound rate of growth					
1978–81	13.0	5.6	7.0	−2.7	10.1
1981–84	−5.5	−1.3	−4.2	−10.5	7.1
1981–82	−11.3	−5.9	−5.7	−11.4	6.4
1982–84	−2.4	1.0	−3.4	−10.1	7.4

TABLE 26

TOTAL U.S. MEDICAID EXPENDITURES FOR OTHER SERVICES, 1978–84

Year or Period	Total Expenditures (Millions of Dollars)	Number of Recipients (Thousands)	Expenditures per Recipient (Dollars)		Medicaid Price Index
			Nominal	Constant	
1978	459.6	6,638.0	69.24	69.24	1.00
1979	556.7	6,490.6	85.77	78.67	1.09
1980	722.9	6,923.6	104.41	85.82	1.22
1981	1,081.6	9,447.2	114.49	85.55	1.34
1982	1,228.2	9,020.8	136.16	91.99	1.48
1983	1,319.5	9,712.3	135.86	83.23	1.63
1984	1,280.4	9,585.2	133.58	76.85	1.74
Annual compound rate of growth					
1978–81	33.0	12.5	18.3	7.3	10.2
1981–84	5.8	0.5	5.3	−3.5	9.1
1981–82	13.6	−4.5	18.9	7.5	10.6
1982–84	2.1	3.1	−1.0	−8.6	8.4

Similarly, data in table 26 showing changes in expenditures for the remaining or "other" acute care services do not support the idea of a general expansion of service coverage. The "other" category consists of such a large set of services that it is difficult to summarize, and some recipients are counted more than once, so it is also somewhat difficult to interpret changes in number of recipients and expenditures per recipient. It is clear, however, that the "other" category grew rapidly before 1981, averaging 33.0 percent a year, as a result of large increases in numbers of recipients, general inflation, and real increases in services. After 1981, expenditures increased by only 5.8 percent a year; recipient growth stabilized, nominal expenditures per recipient grew at a much slower rate, and real expenditures declined These data suggest that the states were very successful in controlling increases in expenditures in these optional services. The data on expenditure changes between 1982 and 1984 do not support the IHPP information on increased service coverage. Although some states are expanding, other states seemingly continue to maintain strong controls on fees and service coverage.

Summary

The major findings of this chapter are as follows.

The 1981–84 period witnessed substantial growth in Medicaid hospital prospective payment systems; by 1985 only fourteen states did not have some form of "alternative" reimbursement methodology. The period also witnessed the expansion of direct limits on utilization and more intensive use of prior authorization to control hospital use. The result was a reduction in the rate of growth in hospital spending from 14.7 percent to 6.7 percent a year. The growth in expenditures per recipient in real terms fell from 3.8 percent a year before 1981 to 0.9 percent afterward.

Expenditures on physician services in Medicaid fell dramatically; the rate of increase was only 2 percent a year after 1981, reflecting a 5.4 percent reduction each year in real spending per recipient. Reductions were due to severe fee restraints imposed by a large number of states and probably to reductions in physician participation and accompanying drops in use of physician services.

Hospital outpatient care continued to increase, though at slower rates than before 1981; the lower growth rates were attributable to smaller increases in the number of recipients and a lower rate of input price inflation. Real expenditures per recipient continued to grow about 2 percent a year. Many states moved away from reasonable cost reimbursement to impose some form

of fee schedule or other alternative method. The real increase in expenditures may reflect a substitution of care that had previously been provided in physicians' offices or as inpatient services.

Other acute care services such as prescription drugs, dental care, and the remaining optional Medicaid services showed substantial real declines after 1981, apparently as a result of aggressive cost-containment policies imposed by many states. It should be noted that these policies could have been adopted by Medicaid programs even without the OBRA legislation.

CHAPTER 5

LONG-TERM CARE

As noted in chapter 2 of this book, long-term care constitutes an increasingly important segment of Medicaid spending, accounting for 49 percent of total spending in 1984 and growing at a faster rate than acute care. As shown in table 27, spending for long-term care increased by 17.0 percent annually between 1978 and 1981, with much of the growth attributable to an increase of 5.3 percent a year in real expenditures per recipient. After 1981, the rate of growth in spending for long-term care fell sharply, reflecting slower growth in the number of recipients and a reduction in the underlying rate of

TABLE 27

TOTAL U.S. MEDICAID EXPENDITURES FOR LONG-TERM CARE, 1978–84

Year or Period	*Total Expenditures (Millions of Dollars)*	*Number of Recipients (Thousands)*	*Expenditures per Recipient (Dollars)*		*Medicaid Price Index*
			Nominal	*Constant*	
1978	8,194.1	1,912.5	4,284.52	4,284.52	1.00
1979	9,604.6	1,897.2	5,062.38	4,641.69	1.09
1980	11,148.7	1,962.4	5,681.03	4,740.73	1.20
1981	13,120.2	1,984.0	6,613.01	5,007.24	1.32
1982	14,450.9	1,938.4	7,455.12	5,194.63	1.44
1983	15,718.6	2,002.7	7,848.63	5,136.33	1.53
1984	17,013.5	2,024.0	8,405.76	5,286.74	1.60
Annual compound rate of growth					
1978–81	17.0	1.2	15.6	5.3	9.7
1981–84	9.0	0.7	8.3	1.5	6.7
1981–82	10.1	−2.3	12.7	3.7	8.3
1982–84	8.5	2.2	6.2	0.4	5.8

input price inflation to 6.7 percent. Although the real growth rate for long-term care services was only 1.5 percent a year, this rate still exceeded the real growth rate for acute care, which fell by 1.5 percent a year. In summary, the rates of growth in number of recipients and real expenditures per recipient are increasing for long-term care and declining for acute care. If these trends continue, Medicaid will become predominantly a long-term care program.

Already the Medicaid program has become the dominant purchaser in the institutional long-term care market, as well as a very important purchaser of noninstitutional services (though overshadowed in the latter department by Medicare and Title XX—that is, social services). The prominance of institutional care in Medicaid spending is illustrated by table 28, which shows the 1984 distribution of Medicaid long-term care expenditures by type of service and category of recipient. Of the estimated 2 million Medicaid recipients of long-term care services, more than 75 percent were lodged in some type of institutional setting, and most of these were in nursing homes. Although nursing homes are considerably less expensive than either of the other two types of institutional care—mental hospitals and intermediate care facilities for the mentally retarded (ICF/MR)—all forms of institutional care are extremely costly on a per recipient basis.

Although the discussion treats nursing homes as a group, there are in fact significant variations in costs within the group, which includes both skilled nursing facilities (SNFs) and intermediate care facilities (ICFs). When Medicaid began, care in SNFs was provided as a mandatory service. Subsequently, it was argued that staffing and other certification requirements for SNFs exceeded the needs of many Medicaid patients; as a result, a lower level of nursing home care, the intermediate care facility (ICF), was made an optional Medicaid benefit in 1973. All states now cover ICFs, but the share of patients in SNFs versus ICFs varies widely. State reimbursement policies as well as licensure and certification policies affect providers' decisions to render SNF or ICF care, with the result that a patient who would qualify for SNF care in one state could receive ICF care in another.

In the same 1973 legislation, care in ICF/MRs was added as an optional Medicaid benefit. The cost of this benefit expanded rapidly as states upgraded existing facilities to meet Medicaid standards. These facilities had been fully funded by the states; although the facilities became more expensive, the cost to the state fell because of federal matching payments. The result is that ICF/MRs accounted for 24.9 percent of spending for long-term care in 1984. Care for the mentally ill, in contrast, has remained a relatively minor component of the Medicaid program, accounting for only 6.3 percent of total spending for long-term care. This optional benefit has been carefully restricted by federal legislation: services in a mental hospital can be provided only to the

TABLE 28

TOTAL U.S. MEDICAID EXPENDITURES FOR LONG-TERM CARE SERVICES, 1984[a]

Type of Service	*Total Expenditures (Millions of Dollars)*	*Percentage of Total Long-Term Care*	*Number of Recipients (Thousands)*	*Expenditures per Recipient*	*Percentage of Expenditures on Various Categories of Recipients*[b]			
					Elderly	*Blind and Disabled*	*Children*	*Adults*
Nursing home care	10,926.2	64.2	1,373.3	7,956.35	81.2	18.4	0.3	0.1
ICF/MRs[c]	4,241.6	24.9	139.9	30,327.78	2.4	95.4	2.0	0.2
Mental hospitals	1,062.8	6.3	58.3	18,213.95	38.3	36.6	22.0	3.1
Home health	782.8	4.6	452.5	1,729.83	58.5	37.4	2.1	2.0
Total long-term care	17,013.4	100.0	2,024.0	8,405.76	57.8	39.6	2.2	0.4

a. Totals may not add due to rounding.

b. Eligibility categories defined as in table 14, note b.

c. Intermediate care facilities for the mentally retarded.

population over age sixty-five; people under twenty-one can receive only inpatient psychiatric hospital services; and people between twenty-one and sixty-five cannot be covered. Federal requirements have similarly limited the coverage of home-based care, the last and smallest of the Medicaid long-term care services. In consequence, only 4.7 percent of Medicaid long-term care spending is for noninstitutional care.

In the remainder of this chapter, we review the changes in expenditures, recipients, input prices, and services for each of the four service categories just mentioned: nursing homes, ICF/MRs, home health services, and inpatient mental hospital care. The evidence shows that the growth rates in spending fell for all four service categories. Nursing home care, the largest component of the Medicaid program, had the slowest growth rate both before and after 1981. The remaining services experienced lower rates of growth after 1981, but nonetheless continued to increase in real terms.

Nursing Home Care

The Medicaid program has ended up financing a major share of the development of the nursing home industry in the United States. In 1983, the program accounted for 52.1 percent of all spending for care in nursing homes (including ICF/MRs), but this figure masks Medicaid's actual involvement in the nursing home industry. In fact, the program paid some share of the bill of approximately 70 percent of all nursing home patients. (Patients with financial resources are required to pay a substantial share of the cost of their own care, with Medicaid paying the balance; but these patients are considered Medicaid patients just like any others, so more than two-thirds of the nursing home clientele is subject to Medicaid policies.)

In view of this close involvement of industry and program, it is not surprising that states have been far more active in their efforts to control nursing home costs than, for example, to control hospital costs. The states have a larger stake and more leverage with the former than the latter. Also, states have long had more discretion in setting payment rates for nursing homes than they have for hospitals. In the early years of the Medicaid program, this discretion was enormous: states were generally permitted to pay on the basis of what they could afford, and many paid flat rates.

In 1972, at a time of mounting concern over substandard nursing home care, Congress mandated that nursing homes be paid on a "reasonable-cost-related" basis beginning in 1976. This mandate clearly played a role in the rapid nursing home expansion of the early and mid-1970s. States were required to establish reimbursement rates tied in some fashion to actual costs, and per diem costs surged upward in response. The states did, however, retain con-

siderable discretion in setting rates and they began to use this discretion toward the end of the decade. By now, most states have adopted prospective payment systems with strong incentives for cost containment. In the interest of cost containment and other objectives, states have also made numerous decisions that have resulted in considerable refinement and diversity among reimbursement systems from state to state. Before establishing payment ceilings, for example, many states group homes by size, ownership, geographic area, and the like in order to protect higher-cost (and presumably higher-quality) homes. Some states set ceilings on total costs for each group; others limit individual cost centers. Percentile ceilings can be set at fairly high rates (or not used at all) or at levels as low as the fiftieth percentile. States can use different methods of inflating costs from the base year in which cost reports are examined to the rate year in which they are used for payment. States also employ efficiency bonuses to give nursing homes strong incentives to contain costs. Finally, states have adopted a variety of methods for limiting capital costs, focusing to a great extent on limiting the gains that nursing homes can make from frequent turnover. (Table 29 briefly summarizes the key elements of reimbursement systems in a selected group of states in 1984.)

Recent evidence has confirmed that flat-rate and prospective payment systems are generally more effective than retrospective systems in containing costs (Holahan 1985). The evidence has also suggested that such features as efficiency bonuses, percentile ceilings, and methods of establishing inflation adjustments play critical roles in determining rates of increase in costs. We do not know much at this stage, however, about the effects of these reimbursement systems on case mix and quality of care; many people have voiced concern that state efforts at cost containment will encourage nursing homes to shun the more infirm patients. This concern has prompted at least four states to link their reimbursement rates or ceilings to patient impairment indices. Illinois and Maryland, for example, adjust the overall rate for an individual home upward or downward depending on the case mix of the home. Thus, homes are encouraged to accept the more impaired patients, but not compelled to provide them with a higher level of service. In Ohio and West Virginia, in contrast, payment ceilings vary with patient impairment, so a facility receives a higher payment only if it actually incurs costs for its more impaired patient mix.

States have had flexibility to adopt prospective systems and establish limits at relatively low levels, so cost-containment efforts preceded the OBRA legislation. The data clearly indicate that nursing home payments were not increasing at a rapid rate before 1981.

As shown in table 30, Medicaid programs spent $10.9 billion on nursing home care in 1984. More than 80 percent of these expenditures were for

TABLE 29

CHARACTERISTICS OF SELECTED STATE NURSING HOME REIMBURSEMENT SYSTEMS, SELECTED STATES, 1984

State	*Description*[a]
Alabama	Prospective facility-specific rate; ceilings at sixtieth percentile of allowable costs projected for inflation; efficiency incentive if costs less than fiftieth percentile, equal to half of the difference.
California	Prospective flat rate that differs by level of care, number of beds, ownership, and location; rate set at median of class.
Connecticut	Prospective facility-specific rate; ceilings at 155 percent of median of operating costs; efficiency incentive of 10 percent of difference between costs and ceiling.
Florida	Prospective facility-specific rate; ceilings set at statewide median plus one standard deviation for operating costs and median plus two standard deviations for patient care costs; incentive provision equal to one-third to two-thirds of difference between per diem and class ceiling.
Georgia	Prospective facility-specific rate; ceilings based on seventy-fifth percentile of allowable costs for routine, special services, and other operating costs; efficiency incentives in each center; if costs below ceiling, provider keeps 75 percent of difference up to maximum.
Illinois	Prospective facility-specific rate for operating costs; class rate for nursing and capital; nursing reimbursement based on patient assessment; minutes of direct care multiplied by median wages in each area; operating costs limited to sixtieth percentile of area costs; strong efficiency incentives for both nursing and other operating costs.
Indiana	Prospective facility-specific rate; ceilings set at 190 percent of average allowable costs; efficiency incentive equal to 31 percent of difference between ceiling and actual costs for skilled nursing facilities (SNFs), 37 percent for intermediate care facilities (ICFs).
Iowa	Retrospective system for SNFs, prospective facility-specific rate for ICFs with efficiency incentives; ceilings on SNFs same as Medicare and sixty-sixth percentile for ICFs; efficiency incentives for ICFs.

TABLE 29 (*Continued*)

State	*Description*[a]
Kentucky	Prospective facility-specific rate; ceilings set at 105 percent of median per diem cost per class (SNFs, ICFs); efficiency incentive inversely related to actual costs up to $2.25 per day.
Louisiana	Prospective flat rate for each level of care; ceilings at sixtieth percentile.
Maryland	Prospective facility-specific rate with nursing components paid on a patient-related basis; administrative/routine cost ceilings set at median per diem costs plus 15 percent; other patient care cost ceilings equal to median costs plus 20 percent; efficiency incentives for each cost center equal to 40 percent of amount below ceiling.
Massachusetts	Retrospective system with separate ceilings for facilities grouped by level of care and size; ceilings set at one standard deviation above mean costs; complex set of incentives designed to encourage admission of Medicaid patients, efficiency, and quality.
Michigan	Prospective facility-specific rate; ceilings set at eightieth percentile; efficiency incentive of difference between actual operating costs and ceiling, up to maximum of $1.00 per patient day.
Mississippi	Prospective facility-specific rate; ceilings set at sixtieth percentile of costs weighted by patient days; efficiency incentives if per diems below ceilings equal to difference up to $2.00 per patient day.
Missouri	Prospective facility-specific rate; ceilings set at 125 percent of weighted mean for each level of care; no specific efficiency incentives.
North Carolina	Prospective facility-specific rate for direct care costs, class rate for indirect costs; ceiling on direct care costs at eightieth percentile, indirect patient care rate set at sixtieth percentile; efficiency incentives inherent in class rate.
Ohio	Retrospective system for patient-related services; class rate for administrative and general; patient-related costs subject to ceiling based on patient assessment survey, reduces reimbursement if services needed but not provided; class rate set at mean of base year costs plus inflation.

TABLE 29 (*Continued*)

State	*Description*[a]
Pennsylvania	Retrospective system with peer group ceilings; ceilings for SNFs and ICFs based on Standard Metropolitan Statistical Area (SMSA) and non-SMSA group medians; efficiency incentives for facilities within applicable ceilings equal to 8.5 percent of statewide average costs for proprietaries and 6.0 percent for nonprofits.
Texas	Class rates established for SNFs and two categories of ICFs; costs divided into four areas: patient care, dietary, facility, and administration; rate is sum of 107 percent of group median for each area; rate projected to applicable year; providers keep difference if costs incurred are less than the class ceiling.
West Virginia	Retrospective system for patient-related (nursing) costs; prospective system for other operating costs. Nursing service cost ceilings based on kind and amount of care needed, multiplied by statewide average wage rates; facility reimbursed incurred costs up to ceilings. Other operating costs reimbursed on cost basis with ceilings on most costs set at the mean costs for the class (level of care, bed range, location); efficiency incentives if costs below operating cost ceilings.

a. These descriptions are intended to illustrate general approaches used by states. They lack sufficient detail to fully describe the state's reimbursement systems. Two particularly important elements are the system's methods of projecting from the cost year to the rate year and reimbursing for capital costs.

elderly recipients; most of the remainder were for disabled persons. Expenditures for nursing home care increased by 12.3 percent annually between 1978 and 1981, but the number of nursing home users increased by only 0.2 percent. There was a small increase in elderly recipients (1.2 percent) and a small decline among the disabled (0.5 percent). Expenditures per recipient, however, increased 12.1 percent, which accounts for nearly all the growth. The nursing home market-basket index increased by 9.7 percent; thus, the nursing home sector experienced a 2.2 percent increase in real growth prior to 1981. By the standards of other Medicaid benefits during this period, this rate of growth is relatively low. It most likely reflects states' use of reimbursement and bed supply policies to control nursing home expenditures.

Because of the relative success of the states in controlling nursing home expenditures before OBRA, and because OBRA did not directly affect nursing home care, the expenditure patterns changed much less dramatically than patterns for other services after OBRA. The number of recipients remained

TABLE 30

TOTAL U.S. MEDICAID EXPENDITURES FOR NURSING HOMES, 1978–84

Year or Period	*Total Expenditures (Millions of Dollars)*	*Number of Recipients (Thousands)*	*Expenditure per Recipient (Dollars)*		*Medicaid Price Index*
			Nominal	*Constant*	
1978	6,184.1	1,378.9	4,484.89	4,484.89	1.00
1979	7,124.9	1,375.5	5,179.68	4,748.95	1.09
1980	7,945.5	1,398.6	5,681.03	4,742.09	1.20
1981	8,751.9	1,385.4	6,317.43	4,785.57	1.32
1982	9,500.2	1,345.1	7,063.04	4,922.66	1.43
1983	10,050.5	1,366.8	7,353.34	4,814.60	1.53
1984	10,926.2	1,373.3	7,956.35	4,965.89	1.60
Annual compound rate of growth					
1978–81	12.3	0.2	12.1	2.2	9.7
1981–84	7.7	−0.3	8.0	1.2	6.7
1981–82	8.5	−2.9	11.8	2.9	8.7
1982–84	7.2	1.0	6.1	0.4	5.7

essentially stable, with the elderly again increasing slightly (1.3 percent) and the disabled declining (5.1 percent). This very gradual change in patient mix may signify a trend among nursing homes to move away from serving physically and mentally impaired patients who require more costly care. On a per recipient basis, nursing home spending increased by 8.0 percent between 1981 and 1984. The underlying rate of inflation in nursing home inputs was 6.7 percent; therefore, real growth averaged 1.2 percent a year. This is less than 1 percentage point below the pre-OBRA experience.

Thus, it appears that states have continued to maintain strong controls over their nursing home industry. It is noteworthy that the number of recipients of nursing home care under Medicaid has been essentially unchanged for the past seven years. This is despite growth in the number of people over age sixty-five and of the percentage of people older than eighty-five. Many states, as noted earlier, have made strong efforts to control the growth and supply of nursing home beds. Scanlon (1980), and more recently Harrington and Swan (1986), have shown that the number of Medicaid recipients is strongly affected by the number of beds. Because private patients are preferred, these patients are admitted first, with the remaining beds allocated to Medicaid patients. Restraints on growth in beds therefore will sharply limit access for Medicaid recipients.

The restrictions on bed supply may also be responsible for helping Medicaid control its nursing home expenditures. It is not clear whether the case mix of Medicaid patients has changed; as noted, only four states had case-mix reimbursement systems in 1984. Without adjusting for case mix, nursing homes have incentives to admit patients with lighter care needs. In the face of rising private demand and limited bed supplies, it would not be surprising if Medicaid is moving toward serving fewer patients who are severely impaired and who require more costly care. This in itself could help explain the low rate of real growth in Medicaid expenditures for nursing home care.

Intermediate Care Facilities for the Mentally Retarded

Just as the Medicaid program has played a major role in financing expansion of nursing home care, it has also financed a major expansion of care for the mentally retarded. The legislation establishing coverage of ICF/MRs was originally intended to help states deal with the rising costs of serving this population and to foster an increase in the quality of care provided to these people; but the legislation has also served to transfer much of a fiscal burden from the state to the federal level. States have frequently used the ICF/MR provisions to move people out of wholly state-owned institutions or to upgrade those institutions to meet Medicaid standards. Although the facilities have thereby become more costly in the aggregate, they are generally less costly to the state because of the high federal financial participation.

The Medicaid ICF/MR benefit has grown very rapidly in the past ten years. Between 1973 and 1977 the number of ICF/MR residents increased from 39,000 to 101,000; and by 1984 expenditures on ICF/MRs amounted to $4.2 billion, almost 25 percent of all long-term care expenditures. Although it is clear that most of this growth resulted from states' substituting the ICF/MR benefit for care previously provided wholly at state expense, it is not clear whether the bulk of the substitution is over or whether the Medicaid program will continue to face substantial transfers of patients from wholly funded state facilities into ICF/MRs. By 1982, 57.7 percent of all mentally retarded people in residential settings were in ICF/MRs (see table 31), but the ratio varied widely from state to state (at the extremes, 97.6 percent in Minnesota to zero in Wyoming). Because some populous states such as California, Florida, and Michigan have ratios well below the average, we might still expect considerable expansion of the ICF/MR population. Also, Clauser (1985) found evidence that the majority of profoundly mentally retarded people in the United States are not in ICF/MRs. To the extent these people

TABLE 31

MEDICAID COVERAGE OF RESIDENTIAL CARE FOR MENTALLY RETARDED PERSONS, BY STATE, 1982[a]

State	*Total Residential Care Placements*	*Total Medicaid ICF/MR Residents*	*Medicaid as a Percentage of All Residential Care Placements*
Alabama	1,943	1,470	75.6
Alaska	248	118	47.6
Arizona	1,733	0	0.0
Arkansas	1,695	1,420	83.7
California	27,066	10,374	38.3
Colorado	2,829	2,017	71.3
Connecticut	4,553	1,598	35.1
Delaware	764	513	67.5
Florida	8,060	2,128	26.4
Georgia	3,557	2,493	70.0
Hawaii	857	387	45.2
Idaho	860	482	56.0
Illinois	12,888	8,144	63.2
Indiana	3,961	2,798	70.6
Iowa	4,541	1,673	36.8
Kansas	2,875	2,078	72.2
Kentucky	1,860	1,250	67.2
Louisiana	5,055	4,849	95.9
Maine	1,464	630	43.0
Maryland	3,246	1,851	57.0
Massachusetts	6,722	3,971	59.0
Michigan	11,102	4,002	36.0
Minnesota	7,069	6,899	97.6
Mississippi	2,678	1,614	60.3
Missouri	6,251	1,878	30.0
Montana	761	290	38.1
Nebraska	1,722	980	56.9
Nevada	301	175	58.1
New Hampshire	944	339	35.9
New Jersey	8,731	4,366	50.0
New Mexico	846	553	65.4
New York	25,317	15,577	61.5
North Carolina	4,441	2,762	62.2
North Dakota	1,234	219	17.7
Ohio	10,872	6,040	55.5

TABLE 31 (Continued)

State	*Total Residential Care Placements*	*Total Medicaid ICF/MR Residents*	*Medicaid as a Percentage of All Residential Care Placements*
Oklahoma	3,012	1,803	59.9
Oregon	2,480	1,918	77.3
Pennsylvania	15,567	8,598	55.2
Rhode Island	1,012	881	87.0
South Carolina	3,713	2,665	71.7
South Dakota	1,215	721	59.3
Tennessee	3,528	2,377	67.4
Texas	15,763	14,010	88.8
Utah	1,350	1,148	85.0
Vermont	798	385	48.2
Virginia	4,220	3,616	85.7
Washington	3,734	2,464	66.0
West Virginia	1,031	176	17.0
Wisconsin	5,605	3,548	63.3
Wyoming	629	0	0.0

SOURCE: Steven B. Clauser, "Recent Trends in Medicaid Coverage of Long-Term Residential Care for the Mentally Retarded: Implications for Policy Research," paper presented at a meeting of the Association for Public Policy Analysis and Management, November 1985.

a. Medicaid totals include skilled nursing and immediate care beds in state institutions for mentally retarded persons.

do enter ICF/MRs in the coming years, there will be continued increases in utilization.

Care in ICF/MRs is already extremely expensive. Many mentally retarded patients are severely impaired and require a large number of specialized services, including a twenty-four-hour supervised environment, specialized transportation services, occupational and speech therapy, and the like. Also, the length of stay for most mentally retarded patients is much longer than that for nursing home patients. In recent years, increases in cost per day have outweighted increases in number of recipients in explaining rising ICF/MR benefit costs.

Increases in costs per day have occurred because of general inflation and other reasons. First, there has been a move from large government-operated facilities to smaller, more costly, privately run facilities of fewer than fifteen beds. Also, facilities and services have been continually upgraded to meet federal standards. In addition, there is evidence that the mentally retarded population is becoming more impaired over time (Clauser 1985), thus requiring more costly treatment. Finally, the way states reimburse for care in

ICF/MRs may contribute to rising costs. Typically, states use reimbursement systems similar to those used in SNFs and ICFs, but generally with more lenient ceilings and fewer efficiency incentives. In consequence, ICF/MR rates are considerably higher than the rates for the other types of facilities, as can be seen in table 32, which compares average ICF/MR reimbursement rates with SNF and ICF rates for each state. Whether these rate differentials reflect greater intensity or quality of care, the use of smaller residential facilities, or state leniency in setting rates is not clear.

As shown in table 33, ICF/MR expenditures virtually exploded in the three years before 1981. The annual average increase of 35.4 percent for these years reflects a 12.2 percent annual rate of increase in number of recipients, following the shift of many of these patients from other types of state residential institutions. At the same time, however, real growth in expenditures per recipient averaged 10.0 percent, under the influence of the various factors already cited: movement to smaller facilities, more lenient reimbursement, and changes in case mix.

After 1981, the rate of growth of ICF/MR expenditures slowed considerably. The number of recipients declined slightly overall, perhaps in response to an end of the shift of patients from wholly state-funded institutions to Medicaid, or perhaps in response to growth in community-based care. Real expenditures per recipient, however, continued to grow at a relatively high rate (7.3 percent).

We cannot tell from the data whether ICF/MR expenditures will continue to grow at such relatively high rates. As already noted, we do not know whether the decline in number of recipients will continue. Much depends on the choices of those states that have not developed large ICF/MR programs; if they do develop large programs, obviously the number of recipients—and the amount of expenditures—will continue to increase. Also, because we do not know whether the 7.3 percent annual real growth since 1981 reflects changes in case mix, lenient reimbursement, or changes in types of facilities serving the mentally retarded, we cannot tell whether the changes are short-term and transitional or longer-term trends. All we can say is that ICF/MR expenditures remain the fastest-growing expenditure item in state Medicaid budgets, but they are by no means growing as fast as they were before 1981.

Home Health Care

States have been permitted for many years to provide noninstitutional long-term care services to Medicaid beneficiaries: home health care has been a mandatory service, and personal care and adult day care have been optional. But for a number of reasons, very few states have made extensive use of

TABLE 32

NURSING HOME REIMBURSEMENT RATES FOR ALL TYPES OF FACILITIES, BY STATE, 1983

State	*Skilled Nursing Facilities*	*Intermediate Care Facilities*	*Intermediate Care Facilities for the Mentally Retarded*	State	*Skilled Nursing Facilities*	*Intermediate Care Facilities*	*Intermediate Care Facilities for the Mentally Retarded*
Average	48.60	38.22	80.88				
Alabama	41.55	27.97	95.90	Nebraska	49.30	27.59	79.55
Alaska	104.94	102.85	200.09	Nevada	51.70	42.81	94.18
Arkansas	28.62	27.99	81.47	New Hampshire	69.52	48.05	48.05
California	...	...	...	New Jersey	56.43	48.35	117.96
Colorado	34.90	34.09	69.25	New Mexico	75.70	34.38	82.34
Connecticut	49.60	33.38	45.89	New York	82.80	52.17	...
Delaware	39.58	39.56	69.70	North Carolina	49.59	35.64	99.00
Florida	39.11	37.86	81.36	North Dakota	46.14	34.51	62.51
Georgia	29.59	27.39	88.84	Ohio	43.23	37.42	59.29
Hawaii	98.07	72.27	...	Oklahoma	33.61	28.60	73.02
Idaho	33.60	33.96	89.84	Oregon	47.01	34.31	...
Illinois	33.85	29.80	69.55	Pennsylvania	39.89	32.81	119.89
Indiana	48.14	37.69	55.86	Rhode Island	46.83	42.25	105.46
Iowa	77.04	26.15	98.89	South Carolina	39.55	29.83	52.46
Kansas	...	...	...	South Dakota	33.39	29.66	63.97

Kentucky	45.67	31.88	78.78
Louisiana	34.80	26.81	65.75
Maine	68.91	43.04	86.54
Maryland	44.41	44.41	93.77
Massachusetts	49.27	36.59	107.65
Michigan	38.12	38.12	124.64
Minnesota	54.29	39.77	76.70
Mississippi	32.81	31.18	46.61
Missouri	46.06	35.79	...
Montana	40.08	40.08	59.03
Tennessee	49.46	31.59	82.36
Texas	38.25	28.40	49.24
Utah	48.36	36.33	60.26
Vermont	46.73	46.73	91.04
Virginia	58.22	43.77	71.56
Washington	37.68	...	63.86
West Virginia	45.54	40.78	44.24
Wisconsin	41.52	32.85	90.41
Wyoming	40.71	40.71	...

SOURCE: Robert Clinksdale, et al., "Analysis of State Medicaid Program Characteristics," prepared under contract HCFA 500-81-0040 (Baltimore, Maryland: Health Care Financing Administration, December 1983).

TABLE 33

TOTAL U.S. EXPENDITURES ON MEDICAID INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED, 1978–84

Year or Period	Total Expenditures (Millions of Dollars)	Number of Recipients (Thousands)	Expenditures per Recipient (Dollars)		Medicaid Price Index
			Nominal	Constant	
1978	1,231.8	107.0	11,515.50	11,515.50	1.00
1979	1,549.8	118.7	13,058.10	11,972.22	1.09
1980	2,098.8	127.6	16,449.57	13,730.86	1.20
1981	3,057.8	151.2	20,219.19	15,316.41	1.32
1982	3,476.5	148.7	23,375.14	16,291.56	1.43
1983	4,078.0	151.0	27,000.48	17,678.57	1.53
1984	4,241.6	139.9	30,327.78	18,928.84	1.60
Annual compound rate of growth					
1978–81	35.4	12.2	20.6	10.0	9.7
1981–84	11.5	−2.6	14.5	7.3	6.7
1981–82	13.7	−1.7	15.6	6.4	8.7
1982–84	10.5	−3.0	13.9	7.8	5.7

these benefits. To begin with, the benefit has been relatively limited, that is, only medically oriented services have been covered under home health. (Some states such as New York, Oklahoma, and Michigan have used the optional personal care benefit extensively to cover services delivered by individual providers in individual homes.) Also, states have not been permitted to target services on selected categories, but, rather, have been required to offer these services to anyone meeting the general Medicaid eligibility requirements. States have thus, with good reason, been reluctant to offer generous home health and personal care packages. The states are aware that, although many people who need home health and personal care services enter nursing homes, most survive outside such institutions, receiving something less than medically professional services informally from family and friends or simply doing without. Tapping this potentially enormous reservoir with a broad entitlement program could invite fiscal stress.

To limit the potential for high program costs, some states have adopted stringent criteria of medical need, such as requiring that the patient be homebound or certified as needing particularly skilled care. The intent is to limit the benefit to people needing short-term, skilled nursing services, rather than long-term maintenance. Some states also place limits on the number of home visits, and others have adopted fee schedules with low rates relative to Med-

icare, thereby reducing access. Finally, several states employ prior authorization, as with other services, to limit use of the home health benefit.

As a result of these various provisions, home health expenditures in the Medicaid program amounted to only $419 million in 1981 and served only 381,510 recipients (see table 34). The growth in expenditures during the 1978–81 period, however, was relatively rapid, increasing at annual rates of 28.2 percent. The real rate of increase per recipient was 13.4 percent, seemingly indicating more intensive use of home health services.

In 1981 the OBRA legislation permitted waivers of various Medicaid requirements to allow states to cover home and community-based long-term care services under very different conditions. The intent was to promote these services to substitute for institutional long-term care, while not increasing Medicaid costs. The legislation permitted states to expand the scope of services that could be offered and to target benefits on selected beneficiaries. States may, for example, go beyond financial and categorical requirements to include medical and social factors in targeting benefits. States may also use financial criteria different from those that apply to the general Medicaid population. They may use the same income eligibility requirement for home and community-based services as that for nursing home care.

The principal objective of the home and community-based waiver is to expand the provision of noninstitutional services to the impaired elderly. One

TABLE 34

TOTAL U.S. MEDICAID EXPENDITURES FOR HOME HEALTH, 1978–84

Year or Period	*Total Expenditures (Millions of Dollars)*	*Number of Recipients (Thousands)*	*Expenditure per Recipient (Dollars)*		*Medicaid Price Index*
			Nominal	*Constant*	
1978	199.2	353.6	563.33	563.33	1.00
1979	251.1	333.5	752.93	691.97	1.09
1980	321.7	369.3	871.30	720.03	1.21
1981	419.4	381.5	1,099.40	821.18	1.34
1982	496.6	377.2	1,316.40	910.81	1.45
1983	588.6	421.7	1,395.73	901.69	1.55
1984	782.8	452.5	1,729.83	1,036.51	1.67
Annual compound rate of growth					
1978–81	28.2	2.6	25.0	13.4	10.2
1981–84	23.1	5.9	16.3	8.1	7.6
1981–82	18.4	−1.1	19.7	10.9	8.0
1982–84	25.6	9.5	14.6	6.7	7.5

reason why it is unlikely that costs will decline is that the number of nursing home beds is limited; and if beds become available, there are a number of people prepared to enter nursing homes. It is therefore difficult to substitute in the short term for nursing home days; as a result, noninstitutional services are likely to add to program costs. In the long term, however, expansion of home and community-based programs could obviate the necessity to build new beds. Moreover, home- and community-based waiver program services may essentially enhance the quality of life of people receiving these services relative to the quality of the lives these people would have in nursing homes.

Since the passage of this legislation, the Reagan administration has been extremely concerned about the potential for a cost explosion. Congress and HCFA have established criteria for assuring that total program costs—that is, for home- and community-based care, other noninstitutional services, and institutional services—do not increase. The total number of people served may increase, but total expenditures may not. Although these expenditures may not increase beyond where they would have been without the program, states are required to indicate their methods of projecting what costs would have been without the waiver and to assure that their expenditures with the waiver would be no greater. This provision, perhaps more than any other factor, has limited the growth of these waiver programs.

Perhaps because of limitations on overall expenditures, the waiver provision has had relatively little impact to date. As of March 1, 1986, ninety-one waiver programs were in operation. Twenty-one programs were for model waiver programs serving no more than fifty people, while the remaining seventy were general "Section 2176" waivers, which serve two major target groups: the impaired elderly and the mentally retarded. As of September 1985, approximately 70,000 people were receiving services under the 2176 waiver authority. Fiscal 1985 expenditures were about $266 million, well below spending for nursing home care and traditional home health care and personal care. Spending is not expected to grow significantly in the near term because of HCFA control on waiver program spending. The recent provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 attempted to expand the program by limiting HCFA's ability to deny waivers and to penalize states for exceeding spending projections. At this writing it is impossible to foresee how much expansion of home- and community-based services will occur (Laudicina and Burwell 1986).

The aggregated data shown in table 35 demonstrate that Medicaid home health benefits (including personal care) continued to grow rapidly after 1981. Expenditures increased by 23.1 percent. Unlike the previous period, however, there was a more rapid growth in recipients, increasing annually by 5.9 percent between 1981 and 1984 and by 9.5 percent between 1982 and 1984. The

TABLE 35

TOTAL U.S. MEDICAID EXPENDITURES FOR INPATIENT MENTAL CARE, 1978–84

Year or Period	*Total Expenditures (Millions of Dollars)*	*Number of Recipients (Thousands)*	*Expenditures per Recipient (Dollars)*		*Medicaid Price Index*
			Nominal	*Constant*	
1978	579.1	73.1	7,927.04	7,927.04	1.00
1979	678.7	69.5	9,770.70	8,958.19	1.09
1980	782.8	67.0	11,683.97	9,752.90	1.20
1981	890.9	65.9	13,523.07	10,243.98	1.32
1982	977.6	67.4	14,513.88	10,115.61	1.43
1983	1,001.4	63.2	15,856.71	10,382.18	1.53
1984	1,062.8	58.3	18,213.95	11,368.09	1.60
Annual compound rate of growth					
1978–81	15.4	−3.4	19.4	8.9	9.7
1981–84	6.1	−4.0	10.4	3.5	6.7
1981–82	9.7	2.2	7.3	−1.3	8.7
1982–84	4.3	−6.9	12.0	6.0	5.7

1984 statistics shown in table 35 include recipients and expenditures under home- and community-based waiver programs. Expenditures between 1981 and 1984 increased at annual rates of 16.3 percent, and the home health price index increased by 7.6 percent; thus, real growth in service use was 8.1 percent. It is not possible to distinguish in the data between expenditures on home- and community-based waivers from expenditures on standard home health services use. It seems clear, however, that the combined effect of changes in home health expenditures (including personal care and waiver services) and nursing home expenditures means continued real increases in long-term care costs.

Care in Mental Hospitals

Spending on inpatient mental health care has never been a major component of the Medicaid program, primarily because of numerous restrictions on coverage of different population groups. Coverage is limited to inpatient hospital, skilled nursing, and intermediate care services in mental hospitals for people over sixty-five or under twenty-one, and inpatient psychiatric hospital services only. Also, states have a fair number of alternatives to mental institutions for providing long-term mental health care. They can fund services wholly from state funds; they can provide supplemental SSI payments to

support mentally ill individuals in board and care homes; they can use Title XX funds to provide social services; or they can use Medicaid's SNF or ICF benefits to provide residential nursing and personal care services to the mentally ill in nursing home settings.

Probably because of the restrictions on Medicaid mental health benefits and the availability of alternatives, few states have financed a great deal of care in mental institutions under Medicaid. New York, for example, accounts for more than 57 percent of Medicaid expenditures on inpatient mental health care. As table 35 indicates, in the pre-OBRA years, expenditures were increasing while the number of recipients was declining. In consequence, expenditures per recipient increased substantially, by 19.4 percent, reflecting both general inflation of 9.7 percent and real growth in expenditures of 8.9 percent. The real growth could reflect changes in case mix resulting from deinstitutionalization—presumably, the most severely impaired patients remain institutionalized—and the increased service provided to the patients who remain in institutions.

Between 1981 and 1984, expenditures on inpatient mental health care increased much more slowly than in the pre-1981 period. Once again, the number of recipients declined (by about 4 percent a year). Expenditures per recipient grew at a slower rate as well, both because of a lower underlying rate of input price inflation and because of a lower real growth rate in expenditures (3.6 percent).

Summary

The major findings of this chapter are summarized as follows.

States continued to exercise strong control over growth in Medicaid expenditures for care in skilled nursing and intermediate care facilities. States were reasonably successful in controlling costs before 1981 and the success continued through 1984. This success reflected a continued use of prospective payment systems to control outlays as well as direct controls over increases in the supply of nursing home beds. From 1981 through 1984 the number of Medicaid recipients in nursing homes declined slightly despite the growth in the number of elderly in the U.S. population.

Intermediate care facilities for the mentally retarded grew 35 percent a year between 1978 and 1981. This figure reflected growth of more than 12 percent a year in the number of recipients, as states began to use the ICF/MR benefit as a substitute for care previously provided in fully state-funded institutions. Between 1981 and 1984 the number of recipients showed a small drop each year, but real growth in spending per recipient continued, apparently because of a change in case mix, relatively lenient reimbursement, and a

move to smaller and more expensive facilities. The result was an increase of 11.5 percent a year in nominal spending, considerably lower than the experience before 1981. ICF/MR spending, however, remains the second-fastest-growing Medicaid benefit.

The fastest-growing Medicaid benefit is home health care. Historically limited in a number of ways by states, home health expenditures grew by more than 28 percent a year between 1978 and 1981 and by 23 percent between 1981 and 1984. The latter growth reflects increases in use of the traditional home health benefit and increases in spending in 1984 on home- and community-based waiver services. As a result, between 1981 and 1984 the number of recipients grew 6 percent a year, accompanied by 8 percent a year growth in real expenditures per recipient.

CHAPTER 6

CONCLUSIONS AND POLICY RECOMMENDATIONS

In the preceding chapters we have examined a sizable body of data pertaining to the recent history of the Medicaid program. Our primary interest was to illuminate the changes in the program since passage of the Omnibus Budget Reconciliation Act in 1981. In particular, we wanted to determine whether the spiraling costs that have plagued the program since its inception may now be regarded as under control and whether other problems with the program should now receive greater attention. The answer to both questions is a cautious yes. In the remainder of this chapter we review our major findings and identify some questions that our analysis could not address. We also briefly survey recent proposals for changes in the administration and financing of Medicaid and outline a proposal of our own.

Major Findings

Among the least surprising but still disturbing of our findings was the extremely wide variation in Medicaid spending patterns among the states, which raises issues of equity for both taxpayers and recipients. Previous studies had documented large differences in spending by state, but a priori reasoning suggested these differences might have shrunk in recent years. Many of the states operating the most generous Medicaid programs have made extensive efforts to curb expenditure growth, while many of the states operating smaller programs have experienced relatively high growth. Nevertheless, the differences remain marked: total per capita spending in 1984 varied among the states by a factor of ten. These large differences in spending held true for both acute and long-term care and across all eligibility groups. Furthermore, they were attributable to wide discrepancies in percentages of the state's population that receive Medicaid services and in the level of expen-

diture per recipient. Differences in the latter were attributable to price and utilization differences.

The wide variation in spending defies easy explanation. It cannot, for example, be attributed to differences in poverty rates, because variations in expenditures per person in poverty are even greater than variations in expenditures per capita. In general, expenditures per capita are lower in states with a greater incidence of poverty. Because states do not provide benefits to cover all the poor, increases in poverty tend not to affect spending but to increase the queue of people who need care.

Spending seems to be determined by some combination of factors reflecting ability and willingness to pay. As state per capita income increases, for example, the percentage of poor people who are covered increases. Also, states that have more physicians, nursing homes, and the like spend more, but because these states also tend to have higher incomes, the impacts of the two factors cannot be clearly distinguished. The level of federal financial participation partly offsets the effects of income. The federal government pays a higher share of Medicaid costs in lower-income states, with the result that somewhat greater spending is stimulated in those states than would otherwise be the case. The stimulating effect of the federal matching rate is not, however, sufficient to offset the effects of income. Finally, *independent of income and federal matching rates*, spending varies substantially by geographic region, reflecting the different political philosophies of different parts of the country. Relative to the Midwest, per capita expenditures are on average 28 percent higher in the East, 42 percent lower in the South, and 25 percent lower in the West. Expenditures on different eligibility groups and different types of care (long-term or acute) also vary to some extent by region.

Investigation of changes in expenditures over time, as opposed to across states, revealed spending patterns after OBRA very different from those prevailing before its passage. Before 1981, real growth in Medicaid spending averaged more than 5 percent a year; after 1981, real Medicaid spending remained essentially constant. Before 1981, the number of recipients increased annually by only a small amount, while real expenditures per recipient increased by an annual average of 5.2 percent. After 1981, the number of recipients declined by 0.7 percent a year, while real expenditures per recipient annually rose by 0.7 percent. Thus, the general structure of spending patterns in the Medicaid program seems to have changed.

The change has affected various eligibility groups differently. It has hit the AFDC categories particularly hard. Whereas the number of adult and child recipients increased slightly, real expenditures per recipient fell (by 4.8 percent a year for adults and 3.1 percent for children). In contrast, real spending on

aged and disabled people increased (by 3.1 percent a year and 1.9 percent, respectively), while the number of recipients in both groups declined slightly.

These patterns are consistent with the patterns of spending on specific services. Real expenditures for acute care services—those services used most intensively by the AFDC population—declined after 1981, reflecting annual declines in the number of recipients and in the real expenditures per recipient. The reverse was true for long-term care: number of recipients and real expenditures per recipient both increased. As a result, within a six-year period the share of total program spending devoted to long-term care grew from 46 percent to almost 50 percent.

Beyond describing these broad changes in spending for groups and services, we wanted to determine how the Medicaid population compares with the population in poverty both pre- and post-1981, because one of the explicit goals of the OBRA provisions was to promote tighter targeting of Medicaid benefits on the poor. We found that the number of elderly enrollees fell by 6.8 percent between 1980 and 1984. The number of elderly persons in poverty declined even more, by 15.5 percent, with the result that the likelihood of a poor elderly person being on Medicaid actually increased. The picture for adults and children is very different, however. While the number of adults and children covered by Medicaid increased by 3.9 and 3.6 percent, respectively, their respective numbers in poverty rose substantially faster (by 22.3 and 16.6 percent). The result is a significant decline in the likelihood of a poor adult or child being on Medicaid.

In 1984, Medicaid coverage of the poverty population was fairly limited, though varying greatly among states. Nationally, Medicaid covers only 35.8 percent of poor elderly persons, 34.0 percent of poor adults between the ages of eighteen and sixty-four, and 49.5 percent of those under age eighteen. Current information on percentages of the poor who are covered are not available by state, but the wide variation in Medicaid enrollment as a percentage of state's population in 1979 (ranging from 3 to 13 percent) and an apparent inverse relation between the percentage of state populations covered and the percentage of poor people suggest that coverage proportions for many states are likely to be much lower than the national averages just cited. These substantial variations reflect very great differences in state decisions on income standards to be used in establishing eligibility and on coverage of optional groups.

The reductions in Medicaid eligibility is not the only area in which OBRA aims appear to have been realized. The OBRA provisions intended to curb growth in expenditures for hospital inpatient services also appear to have been effective. Of particular note in this regard were the provisions permitting

states greater flexibility in implementing prospective payment systems for hospital costs. These costs account for more than half of all acute care spending; before 1981 they had been growing at a real rate of almost 4 percent a year. After 1981, real expenditures per recipient grew by only 0.9 percent. If we exclude changes in expenditures for the elderly population (largely reflecting increases in Medicare's hospital deductible), there would be virtually no growth in real terms.

It seems likely that the reduction in the growth of hospital inpatient expenditures is attributable to the widespread adoption of prospective rate-setting systems by Medicaid programs, as well as to the general decline in hospital costs nationally. From the available data, however, we could not determine what part of the reduction was due to the change in rates and what part to changes in service utilization (for instance, days, admissions). Nor could we determine the effects of Medicaid prospective payment systems on access to care for Medicaid beneficiaries, for example, whether prospective payment systems are reducing unnecessary admissions and unnecessarily long hospital stays, or whether they are lowering quality of service and restricting access. Finally, we could not tell whether changes in policy have reduced the number of hospitals serving Medicaid patients, whether the mix of hospitals caring for these patients has changed (for example, fewer nonprofit teaching hospitals), or whether other types of care (outpatient departments, nursing homes, home health agencies) are being substituted for hospital care.

The change in the pattern of spending for care by private physicians was even more dramatic than that for hospitals, but harder to explain. Throughout the recent history of the Medicaid program, states have imposed strong controls on fees and various limits on services provided by physicians. As a consequence, expenditures on physician care stayed essentially constant in real terms before 1981. After 1981, the number of recipients declined slightly each year, but expenditures per recipient declined fairly precipitously (more than 5 percent a year). We lack the data to determine how much was due to changes in Medicaid rates relative to changes in physician fees generally, or how much was due to a lower rate of participation of physicians in the Medicaid program. The sharp drop in spending can probably be explained by declines in fees and participation, but the drop raises some important questions: Is it now true that Medicaid recipients in many states have very limited access to specialists, particularly obstetricians and internists? Do Medicaid patients now rely more on hospital outpatient departments and emergency rooms for their care, or do they simply have less access to care from any source?

The low fees and low rates of physician participation in the Medicaid program also have implications for future state cost-control efforts. In the interest of further controlling acute care expenditures in the Medicaid program,

the OBRA legislation allowed states to apply for "freedom of choice" waivers to permit them to experiment with capitation and case management systems. But given the already low fees and poor participation, the program probably cannot save a great deal of money through these approaches. Capitation arrangements are unlikely to reduce costs in most states because physicians will probably not go at risk for low capitation rates, and capitation rates high enough to attract physician participation could result in higher, not lower, program spending. Similarly, case management programs that do not place physicians at risk are likely to result in increases in program costs, because case managers are more likely to find substantial unmet needs for care rather than excessive use of services.

The substitutability between hospital outpatient care (and emergency rooms) and physician services and inpatient hospital care is very important because, unlike spending on the latter, spending on outpatient departments has not slowed appreciably, maintaining a real growth rate comparable to that of the pre-OBRA years. The growth reflects increases in number of recipients and real expenditures per recipient, but it is difficult to tell how much of the growth represents additional real outlays in aggregate versus a substitution of this source of care for that of physicians and inpatient departments. The data do suggest, however, that to the extent case-management and capitation arrangements can reduce the use of hospital outpatient departments (and emergency rooms), they may in fact reduce Medicaid spending.

Spending on the remaining acute care services has fallen in the post-OBRA years. Dental care, for example, is rapidly becoming a relatively unimportant Medicaid service: the number of recipients declined by 1.3 percent a year between 1981 and 1984, while real expenditures per recipient fell by over 10 percent a year. Similarly, the number of recipients and real expenditures per recipient for prescription drugs have fallen off, no doubt partly in response to the extensive policies states have adopted for controlling reimbursement and utilization.

The net result of all these program changes is a substantial decline in the use of acute care service by the Medicaid population. Although some of this decline may be desirable—long overdue changes in hospital reimbursement policy, for example, have undoubtedly produced some gains—some of the decline seems problematic. The decline in spending for visits to physicians, for example, probably translates into potentially serious reductions in patient access. The sharp declines in optional services are harder to interpret. They may reflect appropriate targeting of scarce resources, or they may represent real deprivation of needed services. In summary, although the cost-containment picture for acute care looks brighter than it did, the access picture looks cloudier.

In contrast to spending for acute care, spending for long-term care is continuing to increase. The number of recipients went up 0.7 percent annually between 1981 and 1984, and real spending per person grew by 1.5 percent a year. As a result, real spending on long-term care increased by about 7.0 percent in total over the three-year period. Somewhat surprisingly, the increase in numbers of recipients was not attributable to any expansion of nursing home coverage—which had been a big factor in the rapid growth of the Medicaid program in the 1970s. In fact, the number of nursing home recipients declined slightly during the post-OBRA years, as real expenditures per recipient continued to increase. Because the increases were not large, however, they seem to attest to the continued success of rate controls in the nursing home industry. Most states had imposed prospective payment systems on nursing homes even before 1981, and the industry has clearly responded: costs have risen at slower rates, and the specter of uncontrollable nursing home expenditures has been laid to rest.

In fact, there may be some reason for concern that controls have been *too* effective. The increases over the past several years in the elderly population as a whole and in the percentage of that population over eighty-five years of age, along with the introduction of Medicare prospective payment for hospital care, should have increased the demand for nursing home care among Medicaid recipients. That fewer, not more, Medicaid recipients are actually receiving nursing home care is probably attributable to limitations on growth in the supply of nursing home beds. Previous studies have indicated that the increased demand for nursing home services has lengthened the existing queue, which raises the question of what kinds of patients are getting into scarce nursing home beds. In the few states with patient-related Medicaid reimbursement systems, nursing homes are unlikely to discriminate against the patients who are more impaired (that is, more costly to serve). But in the absence of patient-related systems, there are strong incentives to take the healthiest (least costly) patients. If the lengthening patient queue is encouraging this type of patient selection, it would help explain the decline in number of recipients of nursing home care and the relatively low rate of growth in real expenditures.

More difficult to explain is the decline in number of recipients of ICF/MR care (intermediate care facilities for the mentally retarded). Like nursing homes, this category of care expanded rapidly in the 1970s and, also like nursing homes, cost per recipient continued to grow in the post-OBRA years. (In fact, the growth was so strong that, despite the decline in numbers of recipients, expenditures on ICF/MR care remain the fastest growing item on state Medicaid budgets.) It is impossible to tell whether the explosion in the rolls of ICF/MR recipients is essentially over or whether this is just a temporary

lull. It may be that states have substituted home- and community-based services for care in ICF/MRs and that the high growth rate in expenditures per recipient for this care reflects the more impaired case mix that results from moving the people best able to function on their own into the community. But the available data do not support a clear conclusion.

We did, however, find substantial growth in the number of recipients of home health services, which would seem to support this hypothesis. This increase (more than 60,000 people between 1981 and 1984) was much greater than the drop in number of recipients of either nursing home or ICF/MR services. If substitution is going on, it appears to be in addition to a real expansion of noninstitutional care. Although some of the expansion can be attributed to the OBRA waiver program for home- and community-based care, the states also appear to be expanding regular home health services on their own initiative, because the number of recipients of these services grew substantially between 1981 and 1983, before the impact of the waiver program could be felt.

The overall implication of these various findings is that many poor people have little or no access to health care under the Medicaid program. Acute care services are particularly constrained for the poor population, with increasingly limited access to physicians, dentists, and other services. The percentage of the poor population that is covered by the program in general is relatively low and in some states extremely low. At the same time, spending levels are very high in other states. Thus, the Medicaid program is not successfully promoting an equal distribution of resources among states.

Despite the ongoing disparities in spending levels, the states in general appear to have been quite successful in containing the growth in Medicaid costs. Growth in program expenditures has virtually ceased, except for that caused by general inflation. The states have been very successful in developing prospective reimbursement systems for nursing homes and for hospitals and in imposing a wide variety of controls on unnecessary utilization. They have also experimented with a wide variety of controls on utilization and payment rates for prescription drugs and other optional services. Finally, they have led the nation's third-party payers in experimenting with capitation systems and other types of incentive arrangements, such as competitive bidding and volume purchasing. At this point, the evidence of low annual rates of growth in expenditures and declines in coverage of the populations for which the program was designed suggests that cost containment should no longer be the dominant objective of the Medicaid program. On the contrary, access should be a major concern: particularly access to basic acute care services for AFDC mothers and children and for chronically disabled persons, and possibly access to nursing home care for elderly and disabled persons as well.

Changing Administrative and Financing Arrangements: Recent Proposals

In the past few years, a number of proposals have been advanced for changing the structure of the Medicaid program. The first major proposal was the Reagan administration's New Federalism initiative. Under this proposal, states were to gain complete responsibility for financing and administering the Aid to Families with Dependent Children (AFDC) and the food stamp programs, while the federal government was to receive full responsibility for Medicaid. Many other programs also were to be turned back to the states. The proposal was never enacted. A major problem was one that would plague any effort to federalize a program with wide interstate variations: adopting a federal program with generous standards would substantially increase the cost of the Medicaid program thoughout the country. Federalizing Medicaid with a more "bare bones" program would leave large residual responsibilities to many states that would have to be funded wholly at state expense.

A more recent proposal is the one put forth by the National Study Group on State Medicaid Strategies, a group composed primarily of state Medicaid directors and other state officials. Their proposal would divide the Medicaid program into two broad components—one funding acute care services for families and disabled persons, and the other covering long-term care. The acute care component would be fully federally financed and administered and would thus give the federal government complete responsibility for the basic health care needs of the poor. The aims are to emphasize the provision of preventive services for children and young mothers; to address the problems of interstate inequities in eligibility, benefits, and reimbursement policy; and to foster better interaction between Medicaid and Medicare. For acute care services, the proposal would eliminate the tie to the AFDC and SSI eligibility requirements and extend eligibility to all persons with incomes under 55 percent of the poverty level; all persons with incomes above that level would be covered by a spend-down provision.

The proposal also provides for a nationwide minimum benefit package, which would include all acute care services: hospital inpatient, outpatient, surgery, X-ray, laboratory, physician visits, prescription drugs, preventive care for children and young mothers, dental care for children, limited inpatient and outpatient mental health benefits for acute mental problems, and 100 days of posthospital skilled nursing facility (SNF) care. Advocates of the proposal note that, although the minimum package would be available on similar terms across the country, not all services need to be made available to all recipients, because certain services are more important to certain groups than to others

(for example, dental care for children). To finance the increased costs resulting from the expansion of eligibility and benefits, the group proposes that all services be provided by organized medical plans that are reimbursed through capitation payments.

For long-term care, the proposal envisages full state administration. The federal government would make so-called capitation grants to the states according to the number of functionally impaired elderly and disabled persons and the number of mentally retarded and developmentally disabled persons. These grants would be indexed to population growth and inflation, and states could augment the grants as much as they wished. The federal government would provide broad guidelines for eligibility and services but essentially few restrictions. Eligibility would be based on the presence of functional limitations, and all potentially eligible persons could obtain needs assessment and screening. Income criteria would be used only to determine the extent to which the public sector would share in financing the needed care. State and local governments would be fully responsible for developing service packages and for targeting benefits. In addition to needs assessment, services would include case management, information and referral, in-home and community-based services, and long-term institutional care in a nursing home or residential facility. Medical care services for the population receiving continuing care would be provided under the existing Medicare program or by the federally financed acute care programs just described.

This proposal offers a number of advantages. Dividing the Medicaid program into separate acute and long-term care programs would address concerns about the declining efforts to finance acute care services for young mothers and children. It would eliminate many of the current interstate inequities by mandating uniform minimum eligibility and minimum benefits for acute care nationwide. The elimination of the tie to AFDC would also remove several current within-state inequities. But retaining state administration of long-term care financing, as opposed to establishing a national program, might result in more flexible and more efficient delivery of long-term care services.

Several aspects of this proposal raise questions about its viability, particularly from a financial standpoint. First, the proposal assumes that Medicaid can attain greater savings from capitation arrangements (25 percent over existing expenditures for acute care) than there is any ground to expect. However desirable capitation arrangements may be in theory, they have proved very difficult to implement: fewer than 5 percent of all Medicaid beneficiaries now receive care under such arrangements. To move from 5 percent to 100 percent would entail enormous structural change. Also, given the low rates at which Medicaid programs currently pay for virtually all acute care services, there is not much room for substantial savings. Capitation arrangements may indeed

lead to better continuing medical care, but they are unlikely to do so at much lower cost.

Second, the study group assumes that increased flexibility will result in states making greater use of the less expensive, noninstitutional services to provide long-term care to the elderly and disabled. Although this may indeed occur, it is unlikely to do so at lower cost. An increasingly large number of studies, including the results of a national channeling demonstration program, have shown that noninstitutional services typically do not substitute for nursing home care, but, rather, represent additional services most often to new populations. Although the extension of service may be desirable on its own merits, it cannot be characterized as providing the "same" benefits at lower cost.

Also problematic is the provision for federal administration of the acute care component. It may be both unlikely and undesirable for the federal government to take on such a role, given current fiscal and political conditions. In the past fifteen years, states have proved to be true innovators in developing reimbursement methods for purchasing services in the medical care market and in designing utilization review systems. They have led third-party purchasers in experimenting with competitive bidding, volume purchasing, and capitation arrangements. Much potential for innovation and flexibility would be lost by federalizing administration of the acute care component, and most of the objectives of federalization could be met by other, less drastic means (as are discussed later).

Finally, there could be a problem with the proposal's provision for financing the long-term care component through a federal capitation payment, with no maintenance of effort required on the part of the states. The study group seems to assume that states would maintain their current levels of effort on their own, but the evidence in chapter 2 on the effects of matching rates on state spending suggests that states would reduce spending from their own sources, thereby reducing the amount of long-term care that is financed through the public sector. This provision would have very undesirable effects on access to long-term care services.

A third approach proposed by Grannemann and Pauly (1983) addresses the issues of inadequate coverage of beneficiaries in some states and high levels of spending in others. The proposal envisages a system of declining matching rates, under which the federal government would pay all the expense of the program up to a certain minimum level (say, 80 percent of the national average of Medicaid expenditures per person in poverty). Matching rates would decline over a specified spectrum of expenditures up to a maximum (say, 120 percent of the national average), after which the states would pay the full cost of additional expenses. Total federal expenditures for each state would be determined by the actual number of persons in poverty in the state

and adjusted by the state's index of medical care prices. Because the federal government would pay a declining share of additional expenditures above the minimum, states would face increasing incentives to curb expansion. Because the formula incorporates adjustments for state cost of living and the number of poor people in the state, it would assure that states with many poor people would be treated more generously, as would states with high medical care expenses. The formula does not, however, adjust for differences in state ability to pay; thus, all else being equal, a wealthy state would have the same matching formula as a poorer state.

Changing Administrative and Financing Arrangements: A New Proposal

As is suggested by the preceding discussion of proposed reforms for Medicaid, the program's financial and administrative arrangements could theoretically be restructured to serve any number of goals. The impediment to reform arises not so much from the theoretical difficulty of coming up with an improvement on the current system—in our view, either of the reforms discussed above constitutes improvement of some sort—as from the practical difficulty of striking an acceptable balance among frequently incompatible goals. The incompatibility of goals has led to a kind of reform stalemate for the program. That is, despite widespread recognition of major structural flaws in Medicaid, the program—until OBRA—remained relatively immune to substantial change at the national level. With the passage of OBRA, the goal of cost control attained preeminence and, as we have seen, major changes ensued. Now, we have argued, cost control seems to have been largely achieved, and other goals should claim our attention.

In the remainder of this chapter, we draw on the proposals described above and set forth a new approach for restructuring Medicaid that would address what we believe to be the most critical of the program's outstanding problems. As identified in the preceding chapters, these problems include the following:

- Extreme variations in eligibility standards and benefit packages among states, resulting in inequities among beneficiaries
- Very high levels of spending on the part of some states, reflecting insufficient incentives for cost control at the margin
- Inadequate spending on the part of some states, reflecting failure to compensate at the federal level for income disparities among the states
- Substantial redistribution of resources among states, resulting in taxpayer inequities

- Apparent state preferences for funding long-term care at the expense of acute care, which may reflect more the relative power of state lobby groups than any thoroughly considered choice consistent with the broad purpose of the Medicaid program.

To address these various problems, we propose to separate the long-term and acute care components of Medicaid and to provide federal support for a basic benefit package in both areas. To establish greater incentives for cost control at the margin a revised program should contain matching rates that decline as expenditures increase beyond a specified level. We would retain the current federal-state sharing of administrative responsibilities but would federally mandate minimum, uniform eligibility and benefit package requirements. Although the provision of uniform eligibility requirements and benefit packages would appear to be courting major cost growth, in fact the proposal has the potential to be budget neutral, depending on how the parameters are set in the formulas that are described here.

The acute care program would mandate coverage of a minimum set of acute care services (such as that in the National Study Group on State Medicaid Strategies proposal) to all people below some percentage (for example, 60 percent) of the poverty threshold. People above that level would be eligible through a "medically needy" type of spend-down provision. States could choose a more generous income threshold but would be liable for higher expenditures at the margin. The federal share of program expenditures would be determined by, first, setting a capitation amount based on the projected cost of covering all people meeting the nationally prescribed eligibility standards for a uniform package of benefits. The cost of the benefit package would be adjusted by state-specific price indexes to arrive at estimates for each state. The federal government would contribute financially to this capitation amount; federal participation would continue to vary inversely with state per capita income relative to the national average of income per capita. However, under this proposal it would also vary with the level of state expenditures relative to the capitation amount.[1] Because establishing the capitation amount involves difficult technical decisions that are ultimately very political, they should be made by Congress based on analysis provided by some independent body.

The idea is that the federal matching rate would be relatively high for expenditures less than some percentage, say, 0.8 of the capitation amount; would fall to a lower percentage of the base rate for expenditures between,

1. The capitation amount, CAP, would be determined as follows:

$$CAP_t = N_t \cdot B \cdot P_t + N_t^s \cdot B^s \cdot P_t ,$$

say, 0.8 and 1.2 of the capitation amount; and would fall even further, perhaps to zero thereafter. Under this arrangement, the federal government would share at a very high rate in first dollars of state expenditures. In addition to being required to offer a basic set of benefits to a predetermined pool of eligibles, states would be given generous amounts of federal assistance in providing this basic coverage, so the minimum-level program would be highly subsidized nationally. (States would also be penalized if enrollment fell below a predetermined target participation rate.) States could choose to use more generous eligibility criteria as well as a broader set of benefits. The risk is that states' expenditures would begin to considerably exceed their capitation amount. At some point they would bear the full financial burden for remaining expenses. The overall effect would be to establish a national minimum level of coverage while placing states at greater risk the more generous their programs became.

These parameters are used for illustrative purposes only; cost considerations might dictate the use of others. For example, the higher the income standard used for eligibility, the more generous the benefit package; and the larger the sharing parameters (that is, 0.8, 1.2), the greater federal expenditures will be. Congress could adjust any of these to achieve federal spending objectives. To counteract the pressures against acute care spending, it might also prove desirable to have higher matching grants for acute care than the

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where CAP = the capitation level for state i
N_i = the number of individuals meeting the income eligibility standards in state i
B = the national average cost of the standard benefit package
P_i = an index of state cost levels
N_i^s = the number of persons projected to be likely to spend down to state income eligibility standards in state i
B_s = the national average cost of the standard benefit package for persons spending down.

The federal financial participation would vary inversely with both state income per capita relative to the national average of income per capita and state expenditures per eligible relative to CAP. That is,

$$FFP = \alpha(X_i < 0.8\ CAP_i) + \beta(0.8\ CAP_i < X_i < 1.2\ CAP_i) + \gamma(X_i > 1.2\ CAP_i),$$

where FFP = the federal financial participation rate
α, β, γ = the federal share of expenditures at different levels of state spending; the federal share would also be inversely related to state income as at present

current levels. For example, depending on the states' per capita income, the federal share might range from 0.9 to 0.6 for low levels of state Medicaid spending relative to the capitation amount, from 0.6 to 0.4 for moderate levels of spending, and from 0.3 to 0.2 for higher levels of spending.

The long-term care program would be organized and financed similarly, differing primarily in the determination of the capitation base and in the lower structure of matching rates. The capitation base would take into consideration the size and age structure of the elderly population, as well as the estimated number of mentally retarded/developmentally disabled and chronically mentally ill. A broad range of institutional and noninstitutional services (such as services covered under the home- and community-based waiver program) might be covered. The capitation base would also, as with acute care, incorporate the national average cost of a basic benefit package and the state's cost index.[2]

Clearly the cost of the program is critically dependent on the number of people meeting the national eligibility standards and the cost of program benefits. Eligibility could be established to include only those types of people now receiving Medicaid long-term care services or could encompass a larger population of impaired persons. Similarly, the benefit structure could include

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X_i = actual state expenditures
CAP_i = the capitation level as defined above.

2. Put in the most general terms (that is, without specifying particular benefits or eligibility requirements), the capitation formula would look as follows:

$$CAP_i = N_{1i} \cdot B_1 \cdot P_i + N_{2i} + B_2 \cdot P_i + N_{3i} \cdot B_3 \cdot P_i + N_{4i} \cdot B_4 + P_i + N_{5i} \cdot B_5 \cdot P_i.$$

where CAP_i = the capitation grant base for the state
N_{1i} = the number of elderly people aged sixty-five to seventy-five in state i below the income threshold
B_1 = the national average cost of the benefit package for people aged sixty-five to seventy-five
P_i = the state's long-term care cost index
N_{2i} = the number of people aged seventy-five to eighty-five in state i below the income threshold
B_2 = the standardized cost of program benefits for people aged seventy-five to eighty-five
N_{3i} = the number of people aged eighty-five and over in state i below the income threshold
B_3 = the standardized cost of program benefits for people aged eighty-five and over
N_{4i} = the number of people who are mentally retarded or developmentally disabled in state i below the income threshold

only the current institutional and (restricted) noninstitutional services or a broader set of services. These issues will make a large difference in the cost of the program. Assume, for example, the following distribution of potential outlays for 1,000 functionally impaired elderly people:

Number	*Benefit*	*Total Current Cost*	*Status*
200	$1,000/month	$200,000	Current nursing home residents
100	$500/month	$ 50,000	Current users of home- and community-based care, home health or personal care
300	$833/month	$250,000	All current long-term care recipients
700	0	0	Currently ineligible population
1,000	$250/month	$250,000	Current program costs for at-risk population
700	$200/month	$140,000	Estimated cost of serving currently ineligible population
1,000	$390/month	$390,000	Estimated cost of expanded program

The number of people in the capitation base will depend on the size of the functionally impaired population the Congress elects to cover. The value of the benefit package will vary not only with current costs but also with estimates of the costs of added benefits. The estimates of the benefit package would include projections of patient cost sharing. For example, the more generous the federal government is in terms of increasing the income threshold to establish eligibility standards the more it can assume states can impose cost sharing on the use of noninstitutional services. Under current arrangements, people who have higher incomes are eligible for nursing home care but not for noninstitutional services. This situation results in an obvious bias

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B_4 = the standardized cost of program benefits for people who are mentally retarded or developmentally disabled

N_{5i} = the number of people who are chronically mentally ill in state i below the income threshold

B_5 = the standardized cost of program benefits for people who are chronically mentally ill

toward institutionalization; at the same time, however, patients are required to use their assets and incomes to pay for nursing home care. Under this proposal, the income eligibility standards would be the same for both institutional and noninstitutional services, but patients would be expected to share the cost of the latter (which would not necessarily have to be the same as under current policy). Thus, more people could receive care outside institutions, but the costs would be limited because patients would share in the expenses.

The capitation amount for each state would increase directly with the breadth of both the eligibility standards and the benefit package. The decisions on eligibility standards and benefit structure that the federal government would mandate and provide federal financial support for are clearly political ones to be made by the Congress. Once the capitation amount was determined for each state, the federal government would share in the costs according to a formula like that given above for acute care. That is, federal financial participation would vary inversely with the state's income and the level of total expenditures. In light of the apparent willingness of states to fund real expansions of long-term care under the current matching arrangements, a lower structure of rates than for acute care may be sufficient to meet society's objectives.

States could, as before, establish more generous eligibility standards and benefit packages. States could also establish their own cost-sharing provision for both noninstitutional and institutional services. The marginal costs of added benefits increase until the states ultimately pay full incremental costs. In contrast to the current arrangements, the federal government would be protected against substantial increases in use of noninstitutional services. Thus, the need to establish stringent regulatory controls on state program spending (for example, the current waiver formula limiting expenditure increases) would be eliminated.

The formulation of Medicaid financing just outlined offers a number of advantages over the current system:

It would provide a means for redressing the ongoing shift in spending priority from acute to long-term care, without sacrificing state choice at the margins.

It would promote beneficiary equity by establishing uniform eligibility requirements and minimum benefits, without sacrificing the benefits of state administration. Mandating uniform eligibility criteria (including income standards) is particularly important, given the evidence on widespread discrepancies among states in establishing income standards and covering optional eligibility groups.

It would retain use of the matching formula as an incentive for some states to increase spending and for others to contain costs; the results of this study show that matching rates clearly affect spending levels. These incentives would in fact be strengthened because federal matching payments would be inversely related to the amount of state spending vis-à-vis its target.

It would also promote taxpayer equity by increasing federal outlays in low-spending states and limiting them in high-spending states, thus eliminating much of the current income redistribution among states. And it would compensate for differences in the cost of services by state—not addressed in the present cost-sharing formula—while continuing to recognize disparities in state income.

It would enable policymakers to confront a problem that lies at the core of the current debate over Medicaid financing of long-term care—that is, how to provide greater federal financial support for expanded use of noninstitutional services without setting off a cost explosion. Under the current system, noninstitutional care has remained a rather tightly constrained option, because state and federal governments fear uncontrolled growth in the ranks of noninstitutional care users if the service is offered as a national entitlement. Under our formula, the federal risk would be limited by the declining matching rates and the states would have their choices constrained only by cost, rather than by complex federal regulations.

In summary, we believe that restructuring the Medicaid program along the lines sketched here would serve the interests of equity and cost control. Although total federal costs could be higher than at present, they need not be; as already noted, the parameters of the formulas could be set to maintain expenditures at current levels. Regardless of the parameters, however, the poorer states would gain under the formula and the states that spend well above the norm would lose. In view of the extreme variations in spending levels, population coverage, and benefits documented in this book, all of which are related more to ability and willingness to pay than to measures of need, this outcome seems highly desirable.

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APPENDIX A

The Medicaid Price Index

The price index used to adjust Medicaid expenditures for inflation over the 1978–84 period was based on the HCFA hospital and nursing home market basket indexes and selected components of the medical care consumer price index (MC-CPI). The market basket indexes and MC-CPI components used to create the Medicaid Price Index (MPI) and its components were as follows:

Inpatient hospital	HCFA hospital market basket
Outpatient hospital	HCFA hospital market basket
Nursing home	HCFA nursing home market basket
ICF/MR	HCFA nursing home market basket
Inpatient mental health	HCFA nursing home market basket
Home health	MC-CPI professional services component
Dental	MC-CPI dental services component
Physician	MC-CPI physician services component
Other	MC-CPI other medical care component

Price changes for MC-CPI components were measured from March to March, that is, from the midpoint of one federal fiscal year to the midpoint of the next, to make the MPI correspond to the period covered by the expenditure data.

To create the indexes for acute and long-term care services, price changes for the appropriate service components were weighted and then summed to produce a weighted average index for the service grouping. Weights were based on the proportion of the group's total expenditures accounted for by each service. For example, if inpatient hospital expenditures accounted for 50 percent of total acute care expenditures, price changes in the HCFA hospital market basket index were weighted to account for 50 percent of the change in the index used to adjust acute care expenditures for inflation.

The index for total services was weighted in the same manner. In addition, weights were adjusted each year to reflect changes in the mix of services

over time as well as changes in prices. That is, the MPI is a specific-year weighted (Paasche) rather than a base-year weighted (Laspeyres) price index. This is the methodology used to construct the implicit price deflator (IPD) for the gross national product, thus making the MPI equivalent to an IPD for the Medicaid program.

APPENDIX B

Data on Total U.S. Expenditures and Recipients, Various Services and Medicaid Populations, 1978–84

TABLE 36

TOTAL U.S. EXPENDITURES AND RECIPIENTS, VARIOUS MEDICAID POPULATIONS, BY SERVICE, 1984[a]

Medicaid Population and Type of Service	*Total Expenditures (Millions of Dollars)*	*Percentage of Total Spent on Medicaid Population*	*Numbers of Recipients (Thousands)*	*Expenditures per Recipient (Dollars)*
Elderly				
Hospital	1,449.7	11.30	812.0	1,785.25
Nursing home	8,871.2	69.15	1,179.6	7,520.34
Physician	283.9	2.21	2,153.0	131.86
Outpatient	147.9	1.15	1,047.4	140.90
ICF-MR[b]	103.4	0.81	4.5	23,173.72
Inpatient mental	406.6	3.17	20.3	19,986.80
Home health	458.1	3.57	210.8	2,173.22
Dental	29.8	0.23	262.7	113.54
Pharmacy	776.9	6.06	2,491.6	311.79
Other	301.2	2.35	1,751.9	171.91
Total	12,828.4	100.00	3,153.4	4,068.14
Blind and disabled				
Hospital	3,103.0	25.11	733.4	4,230.88
Long term	2,007.7	16.25	232.1	8,650.07
Physician	601.3	4.87	2,069.3	290.61
Outpatient	734.8	5.95	1,683.0	436.59
ICF-MR[b]	4,045.5	32.74	137.6	29,399.61
Inpatient mental	389.3	3.15	20.8	18,689.85
Home health	293.0	2.37	165.3	1,772.39
Dental	56.5	0.46	501.5	112.67
Pharmacy	695.0	5.63	2,217.3	313.47
Other	429.9	3.48	1,442.6	298.02
Total	12,356.1	100.0	2,860.6	4,319.36

TABLE 36 (*Continued*)

Medicaid Population and Type of Service	*Total Expenditures (Millions of Dollars)*	*Percentage of Total Spent on Medicaid Population*	*Numbers of Recipients (Thousands)*	*Expenditures per Recipient (Dollars)*
AFDC and other Medicaid children				
Hospital	2,164.3	45.15	926.9	2,334.97
Long term	39.0	0.81	16.4	2,373.68
Physician	758.1	15.82	6,835.7	110.90
Outpatient	743.9	15.52	4,999.8	148.79
ICF-MR[a]	84.7	1.77	4.9	17,209.17
Inpatient mental	234.3	4.99	16.0	14,657.05
Home health	15.9	0.33	50.5	314.92
Dental	236.9	4.94	2,931.0	80.82
Pharmacy	227.0	4.74	6,030.8	37.64
Other	289.2	6.03	3,940.3	73.39
Total	4,793.3	100.00	10,039.7	477.44
AFDC adults				
Hospital	2,268.7	50.66	991.9	2,287.30
Long term	8.3	0.19	1.8	4,534.15
Physician	817.1	18.25	3,683.8	221.81
Outpatient	605.0	13.51	3,029.5	199.71
ICF-MR[a]	8.0	0.18	0.4	21,372.53
Inpatient mental	32.6	0.73	2.7	12,287.45
Home health	15.8	0.35	36.8	429.03
Dental	151.1	3.37	1,331.1	113.49
Pharmacy	311.6	6.96	3,654.0	85.27
Other	260.1	5.81	2,602.2	99.95
Total	4,478.3	100.00	5,154.7	868.79

a. Totals may not add due to rounding.

b. Intermediate care facilities for the mentally retarded.

TABLE 37

TOTAL U.S. EXPENDITURES FOR VARIOUS MEDICAID POPULATIONS, 1978–84

Year or Period	Total Expenditures (Billions of Dollars)	Number of Recipients (Thousands)	Expenditures per Recipient (Dollars)		Medicaid Price Index
			Nominal	Constant	
Elderly					
1978	6.3	3,362.4	1,878.36	1,878.36	1.00
1979	7.2	3,362.8	2,127.86	1,951.23	1.09
1980	8.8	3,438.7	2,549.94	2,125.82	1.20
1981	10.1	3,365.7	3,007.72	2,270.19	1.32
1982	10.8	3,238.3	3,341.34	2,310.64	1.45
1983	12.1	3,246.3	3,718.62	2,398.75	1.55
1984	12.8	3,153.4	4,068.14	2,489.54	1.63
Annual compound rate of growth					
1978–81	17.0	0.0	17.0	6.5	9.8
1981–84	8.2	−2.2	10.6	3.1	7.2
1981–82	6.9	−3.8	11.1	1.8	9.2
1982–84	8.9	−1.3	10.3	3.8	6.3
Blind and disabled					
1978	5.6	2,675.9	2,074.86	2,074.86	1.00
1979	6.7	2,714.3	2,484.35	2,276.12	1.09
1980	7.7	2,874.4	2,662.50	2,206.72	1.21
1981	9.6	2,914.2	3,293.83	2,463.46	1.34
1982	10.5	2,837.9	3,695.19	2,521.92	1.47
1983	11.4	2,855.9	3,999.70	2,545.14	1.57
1984	12.4	2,860.6	4,319.36	2,602.60	1.66
Annual compound rate of growth					
1978–81	20.0	2.9	16.7	5.9	10.2
1981–84	8.8	−0.6	9.5	1.9	7.5
1981–82	9.3	−2.6	12.2	2.4	9.6
1982–84	8.6	0.4	8.1	1.6	6.4
All other adults					
1978	2.6	4,369.7	596.89	596.89	1.00
1979	2.9	4,266.7	690.92	632.34	1.09
1980	3.3	4,584.7	711.13	584.64	1.22
1981	3.8	4,879.2	787.84	580.27	1.36
1982	4.1	5,023.4	821.49	547.54	1.50
1983	4.4	5,137.6	865.24	534.07	1.62
1984	4.5	5,154.7	868.79	504.13	1.72

TABLE 37 (*Continued*)

Year or Period	*Total Expenditures (Billions of Dollars)*	*Number of Recipients (Thousands)*	*Expenditures per Recipient (Dollars)*		*Medicaid Price Index*
			Nominal	*Constant*	
Annual compound rate of growth					
1978–81	13.8	3.7	9.7	−0.9	10.7
1981–84	5.2	1.9	3.3	−4.6	8.3
1981–82	7.4	3.0	4.3	−5.6	10.5
1981–84	4.2	1.3	2.8	−4.1	7.2
Children					
1978	3.2	10,047.3	321.54	321.54	1.00
1979	3.4	9,728.4	345.64	316.32	1.09
1980	3.8	9,762.2	384.49	316.21	1.22
1981	4.1	9,958.5	415.67	306.47	1.36
1982	4.1	9,930.7	416.05	278.28	1.50
1983	4.4	9,691.7	456.32	282.92	1.61
1984	5.0	10,039.7	477.44	278.77	1.71
Annual compound rate of growth					
1978–81	8.6	−0.3	8.9	−1.6	10.7
1981–84	5.0	0.3	4.7	−3.1	8.1
1981–82	−0.2	−0.3	0.1	−9.2	10.2
1982–84	7.7	0.6	7.1	0.1	7.0

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